Warren County Pathfinders

Paving the way to possABILITIES

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: $ _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address:

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address:

Full Name: Relationship:

Company: Phone:

Address:

Full Name: Relationship:

Company: Phone:

Address:

Previous Employment

Company: Phone:

Address: Supervisor:

Job Title: Starting Salary:$ Ending Salary:$

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone:

Address: Supervisor:

Job Title: Starting Salary:$ Ending Salary:$

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone:

Address: Supervisor:

Job Title: Starting Salary:$ Ending Salary:$

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

How did you hear about our employment opportunities? (Newspaper, social media, word of mouth etc) _____

Where you referred by a current employee? (Yes or no) If so, name of employee _____

Emergency Contact Information

Name: _____ **Relation:** _____

Phone Number: _____

Name: _____ **Relation:** _____

Phone Number: _____

Warren County Pathfinders

AUTHORIZATION TO RELEASE INFORMATION

To Whom It May Concern:

I have applied for a position at Warren County Pathfinders and have given you as a personal reference/previous employer. I hereby authorize you to release any information concerning my qualifications and or job performances that might pertain to the position I have applied for.

Please forward such information directly to Warren County Pathfinders at the address below, or you may discuss these issues with the hiring supervisor.

Thank you

_____ _____

SIGNATURE DATE

_____ _____

PRINTED NAME SOCIAL SECERITY #

_____

MAIDEN NAME

_____

_____

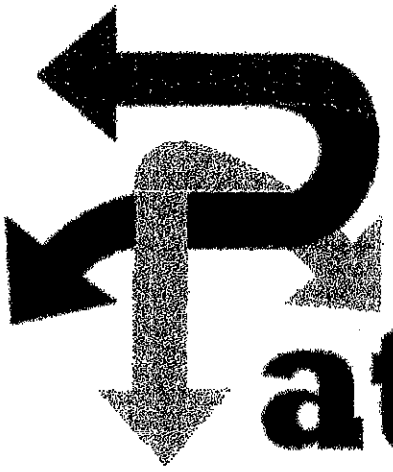
_____

ADDRESS

26321 Dry Fork Rd

Warrenton MO 63383

636-456-7518



Warren County
Pathfinders

PLEASE CHECK ONE,

_____ I am responding to a newspaper advertisement

_____ I am responding to a social media post

_____ I am responding to a posting on Indeed

_____ I was referred by an employee of Warren County Pathfinders

Employee's name _____

_____ Other

Family Care Safety Registry Screening

Full Name: _____
First Middle Last

Maiden/Alias Names: _____

Address: _____
Street City/State

Date of birth: _____ **SS#:** _____
Month Day Year

Go to: www.dhss.mo.gov/fcsr

Is applicant registered: Yes/No If no, information was entered: _____
Date

If yes, screening was completed online _____
Date

Based on the Name, SS# and Date of Birth given above, no finding was reported in FCSR background screening and the written FCSR form should be received by: _____
Date

_____ _____
Signature of Preparer Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102. Register only once!

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent
  - Agency Name: _____
- ☐ Child Care
- ☐ Missouri Foster Parent/Family Member of Foster Parent
  - Children's Division County Office: _____
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right ▸.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

A one-time registration fee of $14.00 applies to all categories except Missouri Foster Parents, who must list the Missouri Children's Division county office.

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐ No

If Yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

___ ___

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)

BIRTH NAME (LIST FULL NAME)	PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER
			☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain: _____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

AUTHORIZATION FORM – *backgroundcheckadvantage.com* 3/3/2023

Background Check ADVANTAGE

First Name	Middle Name	Last Name

Alias/Maiden Name(s)	Will Salary Exceed $75,000?
	☐ No ☐ Yes

Social Security Number	Date of Birth	Race	Gender
			☐ Male ☐ Female

Mailing Address (NO P.O. Boxes)	City	State	Zip

As part of the employment, volunteer, student, credentialing process, I consent to the release of my criminal background records and motor vehicle driving records or any search listed below by any and all states or agencies holding such records. I also agree to an investigation and the obtaining of a consumer report solely for employment, volunteer, student. credentialing purposes. By signing this consent, I acknowledge I have received in writing a Disclosure Regarding Procurement of a Consumer Report. I understand that the Company named above may use this consent on multiple occasions to request such consumer reports.
This consent will remain effective until I have affirmatively revoked it.

☐ I agree to receive all communications regarding any consumer report or investigative consumer report as may be required by the Fair Credit ReportingAct or such other state or local laws via email at my designated email address. (Please mark this box If you agree)

EMAIL: _____ PHONE NUMBER: ( ) _____

_____ **DATE:** _____/_____/_____

Signature of Applicant

BACKGROUND SEARCHES

☐**OIG** (Medicare/Medicaid Fraud & Abuse) ☐**GSA** (Federal Procurement Fraud) ☐****FCSR**

☐**SSN Plus** (Address & Alias Name are included) ☐**FDA Debarment List** ☐ Medicare Opt Out - CMS

☐**Government Watch List** (includes DOC Entity List & Denied Persons List, DOT Specially Designated Nationals & Blocked Persons List, DOS Proliferation List & more)

☐**Wants & Warrants**** (Nationwide - extraditable only) ☐**OFAC** (Specially Designated Nationals and Blocked Persons List)

Child Abuse/Neglect – ☐ **IL**** ☐ **IA**** ☐ **KS**** ☐ **TN** **Adult Abuse/Neglect** – ☐ **KS**

☐**MO Workers Comp** (Special Notarized form Required)**

☐***MO Mental Health Employee Disqualification Registry** ☐**MO EDL** (Employee Disqualification List)

SEX OFFENDER ☐**Nationwide or** ☐**State** **FEDERAL COURTS Criminal** (past 7 years) ☐**Nationwide or** ☐**State**

☐**DRIVING RECORD State** _____ **DL#** _____

☐**PROFESSIONAL LICENSE**

☐**EDUCATION School Name** (include campus): _____

☐**CHARACTER REFERENCE** ☐ **PERSONAL** ☐ **PROFESSIONAL: Name** _____ **Phone:** ____/____-____

☐**EMPLOYMENT Company:** _____ **City/State:** _____/____

LIST CITY/COUNTY CRIMINAL SEARCHES NEEDED

States with county by county access only: CA, LA, MA, NV, WV and WY

County 1:_____**State:** _____ **County 2:**_____**State:** _____ **County 3:**_____**State:** _____

STATEWIDE CRIMINAL - A Statewide/State Repository houses records from all jurisdictions throughout the State

☐ AL*	☐ AK*	☐ AZ	☐ AR*	☐ CO	☐ CT	☐ DE	☐ DC*	☐ FL	☐ GA*
☐ HI	☐ ID**	☐ IN	☐ IA*	☐ KS	☐ KY	☐ ME	☐ MD	☐ MI	☐ MN
☐ MO	☐ MS*	☐ MT	☐ NE	☐ NH	☐ NJ	☐ NM*	☐ NY*	☐ NC*	☐ ND
☐ OH*	☐ OK	☐ OR*	☐ PA	☐ RI*	☐ SC	☐ SD	☐ TN	☐ TX	☐ UT*
☐ VA*	☐ VT*	☐ WA	☐ WI	☐ U.S. Virgin Islands					

Note: Ohio & GA are **Felony** Only

☐ Illinois Statewide Criminal-compliant with IL Healthcare Worker Background Check Act *(IL Police Full-State Repository Criminal Name Only)*

☐ International Criminal _____

FYI: MO-includes MO Sex Offender results at no additional cost *(MO State Highway Patrol Full-State Repository Criminal search)*

***Requires Form(s) & **Requires SPECIAL Form(s)**