Faith Foundation Children's Home

Healing Hearts & Renewing Minds

Derek W. Stricklin, LPC, Executive Director
D. Joy Booth, LPC, IATP, Clinical Program Director
Buck Proffer, Sr. Pastor, CEO

Last Name	First	Middle	Date
Street Address			Home Phone
City, State, Zip		email	Cell Phone
Social Security Number		Date of Birth	Pay Expected
Position Applying For:			Shift Preference:

Have you ever applied for employment with us before?
If so, what month/year?

Apart from religious observance, are you available for full-time work? Yes or No

If not, what hours can you work?

Would you be interested in a PRN (as needed) position? Yes or No

Will you work overtime if asked? Yes or No

When will you be available to work?

Are you legally eligible for employment in the United States? Yes or No

Are you over 21 years of age? Yes or No

Have you ever been convicted of a crime (including convictions following a plea of guilty or no contest) in the past ten years?
Do not include minor traffic violations or convictions that have been expunged from your record. Yes or No

Have you lived outside of the state of Missouri in the last five years? Yes or No
If so, where?

School	Name and Location of School	Course of Study	Number of Years Completed	Did you Graduate?	Degree of Diploma
Graduate					
College					
Business/ Trade					
High School					
Elementary					

Prospective employees will receive consideration without discrimination because of race, creed, color, sex, age, national origin, handicap or veteran status.

Membership in Professional or Civic Organizations

(exclude those which may disclose your race, color, religion, or national origin)

Employment

Please give accurate, complete full-time and part-time employment record. Start with your present or most recent employer.

Company Name:	Telephone:
Address:	Employed - (State Month and Year): __________________ to __________________
Name of Supervisor:	Rate of Pay: Start______________ Last_________________
State Job Title and Describe Your Work: ____ ____	Reason for Leaving: ____ ____

Company Name:	Telephone:
Address:	Employed - (State Month and Year): __________________ to __________________
Name of Supervisor:	Rate of Pay: Start______________ Last_________________
State Job Title and Describe Your Work: ____ ____	Reason for Leaving: ____ ____

Company Name:	Telephone:
Address:	Employed - (State Month and Year): __________________ to __________________
Name of Supervisor:	Rate of Pay: Start______________ Last_________________
State Job Title and Describe Your Work: ____ ____	Reason for Leaving: ____ ____

We may contact employers listed above unless you indicate those you do not want us to contact.

Employer Name:	Number:	Reason:

Did you serve in the Armed Forces?	If yes, what Branch?

Describe the training received relevant to the position for which you are applying:
_____
_____

References

(Please list three references that are not related to you.)

Name	Address	Phone Number
1		
2		
3		

Please provide history of any previous child care settings in the past 5 years:

Description:	Dates:

Mail to:

Faith Foundation Children's Home
Attn: HR Department
P.O. Box 25
Fredericktown, MO 63645

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APPLICANT CONSENT TO REFERENCE CHECKING

We want you to know that we will be checking your references as part of our hiring process. This will include contacting your former employers for the past five years, at least three personal references of whom are not related to you, as well as friends, acquaintances, and business associates. We may ask a series of questions about your personal background, work experience, character, education, personality, and your ability to work with children.

After reading this policy, please indicate by signing this form in the space provided:

I have read and fully understand the foregoing and voluntarily consent to allow Faith Foundation Children's Home to check my references by contacting any person whom they deem to be an appropriate reference. Questions may be asked about my personal background, work experience, character, education, personality, and my ability to work with children.

_____ _____

Signature Date

600 Sargent Ln. | P.O. Box 25 Fredericktown, MO 63645
Phone: 573-783-4400 or 573-783-4405 | **Fax:** 573-783-4409

SHP-159F 09/07

Missouri State Highway Patrol / Missouri Department of Social Services

REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check **ALL** that apply) See reverse side for further instructions.

- ☐ (1) CD Central Registry Child Abuse Search Only - No Charge
- ☐ (2) Name Search - $9.00 (Criminal record, child abuse, or neglect, central registry search)
- ☐ (3) Fingerprint Search
  - ☐ $14.00 (Authorized Statute 210.487)
  - ☐ $20.00 (All other request)

TYPE OF DAYCARE PROVIDER

- ☐ (1) License
- ☐ (2) License Exempt
- ☐ (3) Registered

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, First, MI, Jr., Sr., III)				
MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
ALIAS NAME(S)	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER / STATE /		

ADDRESSES FOR PAST 5 YEARS

STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been found guilty to or been convicted of any criminal act in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been found guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary.)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Children's Division in this state or any state?

☐ YES (Complete section below) ☐ NO, I have not been substantiated as a perpetrator in any child abuse or neglect report.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary.)

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 permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT **(REQUIRED IN INK)**	DATE
SIGNATURE OF REQUESTOR (Required in ink)	DATE
TITLE OF CHILD CARE PROVIDER	TELEPHONE
STATE AGENCY	STATE VENDOR OR CONTACT NO. (If applicable)

CHECK APPROPRIATE BOX

☐ CHILD CARE RELATED EMPLOYMENT	☐ DOH / CCB CHILD CARE BUREAU	☐ SCHOOLS / PUBLIC AND PRIVATE
☐ CHILD CARE RELATED VOLUNTEER	☐ DMH / DMH VENDOR	☐ CD CONTRACT PROVIDER
☐ CD LICENSURE	☐ HEALTH CARE	☐ OTHER _____

COMPLETE RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
Complete your mailing label below
Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE

SEND FEE & FORM TO:

Missouri State Highway Patrol
Criminal Records and Identification Division
P.O. Box 9500
Jefferson city, MO 65102

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.

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
- ☐ Foster Parent/Family Member of Foster Parent (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.)*

A one-time registration fee of **$12.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

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

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)

MAIDEN NAME (If applicable)	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 U.S. territory/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 (Must be signed in blue or black ink.)	DATE OF SIGNATURE (Must be within six months of submission.)
➤	- -

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative