



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

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## 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:

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**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

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. <input type="checkbox"/> (1) CD Central Registry Child Abuse Search Only - No Charge <input type="checkbox"/> (2) Name Search - \$9.00 (Criminal record, child abuse, or neglect, central registry search) <input type="checkbox"/> (3) Fingerprint Search <input type="checkbox"/> \$14.00 (Authorized Statute 210.487) <input type="checkbox"/> \$20.00 (All other request)	TYPE OF DAYCARE PROVIDER <input type="checkbox"/> (1) License <input type="checkbox"/> (2) License Exempt <input type="checkbox"/> (3) Registered
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**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.)

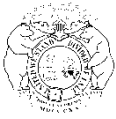
**The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the 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

<input type="checkbox"/> CHILD CARE RELATED EMPLOYMENT	<input type="checkbox"/> DOH / CCB CHILD CARE BUREAU	<input type="checkbox"/> SCHOOLS / PUBLIC AND PRIVATE
<input type="checkbox"/> CHILD CARE RELATED VOLUNTEER	<input type="checkbox"/> DMH / DMH VENDOR	<input type="checkbox"/> CD CONTRACT PROVIDER
<input type="checkbox"/> CD LICENSURE	<input type="checkbox"/> HEALTH CARE	<input type="checkbox"/> OTHER _____

<p style="text-align: center;"><b>COMPLETE RETURN ADDRESS (REQUIRED ON EACH APPLICATION)</b>                  Complete your mailing label below                  Confidential Mail</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="padding: 5px;">AGENCY NAME</td></tr> <tr><td style="padding: 5px;">ATTENTION</td></tr> <tr><td style="padding: 5px;">ADDRESS</td></tr> <tr><td style="padding: 5px;">CITY, STATE, ZIP CODE</td></tr> </table>	AGENCY NAME	ATTENTION	ADDRESS	CITY, STATE, ZIP CODE	<p><b>SEND FEE &amp; FORM TO:</b>                   Missouri State Highway Patrol                  Criminal Records and Identification Division                  P.O. Box 9500                  Jefferson city, MO 65102</p>
AGENCY NAME					
ATTENTION					
ADDRESS					
CITY, STATE, ZIP CODE					



Register online at [www.health.mo.gov/safety/fcsr](http://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.

# WORKER REGISTRATION

**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.)

**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 **\$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](http://www.health.mo.gov/safety/fcsr) or call, toll free, 866-422-6872.

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

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**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 <input type="checkbox"/> M <input type="checkbox"/> 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.)**

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:			<input type="checkbox"/> No Employer, because I am a(n):		
EMPLOYER NAME			<input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent/Family Member <input type="checkbox"/> Home Child Care Provider <input type="checkbox"/> Private Pay/Private Duty <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (Explain: _____)		
EMPLOYER ADDRESS					
EMPLOYER CITY	STATE	ZIP			
EMPLOYER TELEPHONE ( ) -	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE			

**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.

<b>SIGNATURE OF APPLICANT (Must be signed in blue or black ink.)</b>	<b>DATE OF SIGNATURE (Must be within six months of submission.)</b>
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