CVA HOST HOME PROVIDER APPLICATION

Chariton Valley Association

1905 S. High Street, Kirksville, MO 63501

GENERAL INSTRUCTIONS

Please complete all parts of this application, the attached family care registry document and sign both documents. You may bring this application in person to Chariton Valley Association or mail it to: Chariton Valley Association, ATTN: Program Director- HHS, 1905 S. High Street, Kirksville, MO 63501.

SECTION 1: PERSONAL INFORMATION (please print legibly)

Last Name	First Name	Middle Name	Social Security Number	Drivers License Number
Address			Phone (Day)	Phone (Night)
City	State	Zip	Email	
Which county do you reside?	How long?		Hours you currently work	

Please provide information about the individuals currently living in your home or who may be there while you are a Host Home Provider:

Name	Date of Birth	Relationship

Have you ever worked for or do you currently work for CVA? ☐ YES ☐ NO	If yes, please give dates:	Positions(s)
Have you ever applied for foster care license? ☐ YES ☐ NO	Where you denied? ☐ YES ☐ NO	If yes please explain:

Are you currently providing a Host Home, day care or foster care to anyone in your home? ☐ YES ☐ NO	Have you ever been approved to provide Host Home services through any other agency? ☐ YES ☐ NO

Have you ever worked in the field of developmental disabilities? ☐ YES ☐ NO	If yes, please list dates:	If yes please list prior employer(s) and job description in following area and below as needed.

Please provide your current daily schedule, including hours you work and any on-going commitments (including classes, club meeting times, activities, etc.). Please note any schedule changes you anticipate in the next 12 months.

SECTION 2: BACKGROUND CHECK

A CRIMINAL BACKGROUND CHECK IS REQUIRED OF ANY ADULT (persons 18 and older) LIVING WITHIN THE HOST HOME	
Have you or any members of your household been arrested for violations of the law other than minor traffic violations? ☐ YES ☐ NO	If yes, please explain
Have you or any members of your household been convicted of a felony or misdemeanor? ☐ YES ☐ NO	If yes, please explain
Have you or any members of your household been arrested for violations of the law other than minor traffic violations? ☐ YES ☐ NO	If yes, please explain
Are you or any member of your household currently on parole? ☐ YES ☐ NO	If yes, please explain
Do you or any members of your household have a significant health issue that is contagious or terminal? ☐ ☐	If yes, please explain

SECTION 3: EDUCATION, TRAINING AND SPECIAL SKILLS

Please circle highest grade completed. 7 8 9 10 11 12 GED Some College AA BA/BS Other	
Do you have any special certifications in related fields? ☐ YES ☐ NO	If so, what are they?
What is the primary language spoken in your home?	
What other languages do you use fluently?	
Are you proficient in sign language? ☐ YES ☐ NO	List other special skills (if any) that would be helpful as a Host Home provider

SECTION 4: EMPLOYMENT HISTORY

Current Employer (Company Name)			Are you currently working for this employer? ☐ YES ☐ NO If yes, may we contact? ☐ YES ☐ NO	
City	State	Zip	Phone/Fax	Month/Year employment began From to
Briefly describe your position and duties				
Reason For Leaving				

Previous Employer (Company Name)			Are you currently working for this employer? ☐ YES ☐ NO If yes, may we contact? ☐ YES ☐ NO	
City	State	Zip	Phone/Fax:	Month/Year employment began From to
Briefly describe your position and duties				
Reason For Leaving				

Previous Employer (Company Name)			Are you currently working for this employer? ☐ YES ☐ NO If yes, may we contact? ☐ YES ☐ NO
City	State	Zip	Phone/Fax:	Month/Year employment began From to
Briefly describe your position and duties			
Reason For Leaving			

SECTION 5: HOST HOME INFORMATION

Please check the appropriate setting for your home below and indicate number of rooms available for a person to have their own bedroom.

☐ House	☐ Ranch	Total number of Rooms:
☐ Apartment	☐ Single-story	Number of Bedrooms:
☐ Townhouse/Condo	☐ Two-story	Number of Bathrooms:
☐ Mobile Home	☐ Tri-level	Number of Available of Bedrooms:

Location of available bedrooms

Is your home wheelchair accessible? ☐ YES ☐ NO

What hours are you available to provide support services to persons living in your home?

Is any person currently living in your home receiving services from this or any other agency? ☐ YES ☐ NO

Please tell us about the people who may live with you, husband/wife, children, siblings, friend, parents, etc.

I prefer to work with the following age group & people (please check all that apply):

☐ Under 21	☐ 21 - 30	☐ 30 - 50	☐ Over 50	☐ No Preference
☐ Male	☐ Female	☐ No Preference		
☐ One Person	☐ Two Persons	☐ Three Persons	☐ No Preference	

I think I can accommodate an individual who (please check all that apply):

☐ Smokes	☐ Has special Diet Needs or feeding/swallowing difficulties
☐ Uses a cane/walker/wheelchair	☐ Is unemployed or no longer working
☐ Has difficulty with stairs	☐ Has special behavioral needs or concerns
☐ Is Non-Verbal	☐ Has special medical needs/concerns or needs special equipment
☐ Is Visually Impaired	☐ Uses adult depends and/or requires other personal care assistance
☐ Is Hearing Impaired	☐ Uses sign language or needs communication device

Describe your interests that may take you away from the person(s) you will serve.

Who will assist you or provide care to the individual while you are away?

What are your plans for help during emergencies, holidays, vacations, days when CVA is closed, etc?

Please note any pets that share your home.

Do you have any young children who frequently visit your home? ☐ YES ☐ NO	If yes, please give us their ages.

Please give us any other information you would like considered when placing someone in your home.

Activities you frequently participate in or would be interested in sharing with individuals (please check all that apply):

☐ Movies/TV/VCR	☐ Theater	☐ Concerts	☐ Travel
☐ Shopping	☐ Music	☐ Reading	☐ Crafts
☐ Sports	☐ Restaurant	☐ Hiking	☐ Bingo
☐ Jogging/Walking	☐ Camping	☐ Car Rides	☐ Swimming
☐ Photography	☐ Fishing	☐ Gardening	☐ Card Games
☐ Church	☐ Sewing	☐ Bowling	☐ Meeting & Clubs

Other activities you would like to participate in or share with an individual you would serve:

SECTION 6: REFERENCES

Personal References Please provide the following information for 3 **non-relatives** who know you well.

Name	Address	Phone (Home)	Phone (Work)
Type of Relationship		Length of time they have known you	
Name	Address	Phone (Home)	Phone (Work)
Type of Relationship		Length of time they have known you	
Name	Address	Phone (Home)	Phone (Work)
Type of Relationship		Length of time they have known you	

Do you know anyone currently providing services for our agency? ☐ YES ☐ NO	If yes, who?

SECTION 7: APPLICANT SIGNATURE

Applicant Note: This application form is intended for use in evaluating your qualifications to be an Independent Host Home Provider. This is not an employment contract. Please answer all questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the inquiry process or, if discovered after executing a contract, terminating that contract. All qualified applicants will receive consideration without discrimination because of sex, marital status, race, color, age, creed, national origin, sexual orientation, military reserve membership, ancestry, religion, height, weight, use of a guide or support animal because of blindness, deafness or physical handicap, or the presence of disabilities. A felony conviction will not necessarily bar an applicant from consideration. Additional testing of job-related skills and for the presence of drugs in your body will be required prior to execution of a contract.

Certification and Release: I certify that I have read and understand the applicant note above and that the answers given by me to the foregoing questions and to the statements made by me are complete and true to the best to my knowledge and belief. I understand that any false information, omissions or misrepresentations of facts called for in this application, whether on this document or not, may result in rejections of my application or termination of contract at any time during the terms of the contract. I authorize the company and / or its agents including individual reporting bureaus, to verify any of this information. I authorize all former employers, persons, schools, companies and law enforcement authorities to release any information concerning my background and hereby release any said person, schools, companies and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I also understand that the use of illegal drugs is prohibited during the contract period.

Applicant Signature	Date

Missouri Department of Health and Senior Services
Family Care Safety Registry

RESET

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 **$11.00** 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.

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

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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

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 (Optional)	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	Chariton Valley Association
EMPLOYER ADDRESS	1905 South High St.
	Kirksville, MO 63501

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.)
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WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002 as a personal care worker, or hired on or after January 1, 2009 as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 *et seq.*, RSMo.) If you checked Long Term Care / Personal Care, please *also* make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address including street address or post office box, city, state, ZIP code, and county. Include your telephone number. We will use this information to notify you of registration results and any background screenings conducted.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102.** If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872.**

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your mailing address. You can send address changes to Family Care Safety Registry, P.O. Box 570, Jefferson City, MO, 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the *transfer* of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the *substance* of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. A Registry worker will first confirm whether the person in question is registered. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

DISCLOSURE AND AUTHORIZATION FORM TO OBTAIN CONSUMER REPORTS

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you for employment or as a volunteer, intern, or independent contractor, and, if you are employed, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, Chariton Valley Association (CVA) may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment-related decision about you. Information CVA intends to request will include state and national criminal history reports, Missouri driving records, SSN verification, nationwide sex offender reports, Missouri Case Net, terrorists Search, and any and all other screenings as required by contract with the Missouri Department of Mental Health in addition to current and prior work and personal references as specified by you.

Under the Federal Credit Reporting Act (FCRA), before Chariton Valley Association can obtain a consumer report or investigative consumer report about you for employment purposes, we must have your written authorization. Additionally, before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of the report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA. Contact Consumer Financial Protection Bureau at 1-877-382-4357 for more information on reports.

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize the Chariton Valley Association to obtain and rely upon consumer reports or investigative consumer reports in considering me for employment and, if I am employed, in considering me for subsequent promotion, assignment, reassignment, retention, or discipline. By my signature below, I authorize Chariton Valley Association to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I do _____ do not _____ authorize you to contact *my current and former* employer(s) for Employment and Reference Verifications.

(This will authorize immediate inquires to the Human Resources Department and to any listed supervisors or references in the Employment/Reference Section of your application).

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____ _____

Applicant Signature Date

Revised 4-7-14