EMPLOYMENT APPLICATION

ReDiscover

To Applicant: We deeply appreciate your interest in our organization and assure you that we are sincerely interested in your qualifications. A clear understanding of your background and work history will aid us in selecting the most qualified applicants for any available position.

Instructions to Applicant: Use ink. Answer all questions completely. If more space is necessary to answer all questions, attach an additional sheet

Equal Opportunity Employer: As an equal opportunity employer, ReDiscover considers each applicant for employment on the basis of qualifications for the job without regard to race, age, sex, disability, religion, national origin or veteran status.

PERSONAL DATA

Name Last	First		Middle Initial
Address- Street	City	State	Zip
Phone #: Cell:	Home:	Work or Message:	
Email Address:	Are you at least 16 years of age: ☐ Yes ☐ No		
Other names under which you may have been employed:			

Proof of U.S. Citizenship or INS Employment Authorization will be required upon employment.

Do you have relatives employed with us? ☐ **No** ☐ **Yes** **If yes, who?**_____

Relationship:_____ **Dept.:**_____

Are you now, or have you ever been, excluded, debarred or suspended from participation in the Medicare or Medicaid programs or any other federal procurement program? ☐ No ☐ Yes

Have you been convicted of or have you plead guilty to **any** crime or municipal ordinance violation (including misdemeanors and traffic violations) other than a parking ticket? ☐ No ☐ Yes

If yes, complete section below: (conviction will not necessarily disqualify an applicant from employment; however, omission of convictions may be considered falsification of the application which could result in disqualification or discharge from employment). Attach additional pages if needed.

Date:	Charge	City & State	Disposition
Date:	Charge	City & State	Disposition

TYPE OF POSITION DESIRED

Check all applicable availability:

☐ Full Time ☐ Weekends
☐ Part-time ☐ On Call/ PRN
☐ Temporary

Complete the following:

Date Available:_____
Salary Required:_____
# of hours desired weekly:_____

Position(s) applying for:

1. _____
2. _____
3. _____
4. _____

What shifts will you work? ☐ Any ☐ Days ☐ Evenings ☐ Nights

Can you work weekends? ☐ No ☐ Yes Can you work holidays? ☐ No ☐ Yes

Due to the type of services rendered by this institution, you may be required to work a schedule or in an area other than that for which you may be initially hired.

Have you ever filled out an application here before?

☐ No ☐ Yes If yes, when?_____

Have you ever worked for ReDiscover (as an employee, through and agency, or as an independent contractor)?

☐ No ☐ Yes ☐ Currently Employed with ReDiscover ***Please complete "Transfer Application Form***

EDUCATION						
School	**Name of School**	**City, State, Country**	**Degree & Major**	**From: Mo Yr**	**To: Mo Yr**	**Graduate?**
High School/ GED						☐ Yes ☐ No
College						☐ Yes ☐ No
Graduate						☐ Yes ☐ No
School of Nursing						☐ Yes ☐ No
Technical or Professional						☐ Yes ☐ No

PROFESSIONAL LICENSES AND/OR CERTIFICATES (e.g. nursing, chauffeur, commercial, etc.)				
Type	**Active or Inactive**	**State Issued**	**Expiration Date**	**Number**
	☐ Active ☐ Inactive			
	☐ Active ☐ Inactive			
	☐ Active ☐ Inactive			

Have you ever had a professional license/registration denied, revoked, suspended or otherwise restricted? ☐ No ☐ Yes
If yes, provide information, including license/certification, state, date and nature of action:

OTHER SKILLS	**CLINICAL CARE**		**COMPUTER SKILLS**
☐ Accounts Payable	☐ Cath Lab	☐ Mental Health	☐ Database:
☐ Filing Skills	☐ Critical Care	☐ OB/GYN	☐ Graphics:
☐ Medical Insurance Billing	☐ CT Scan	☐ Oncology	☐ Programming Languages:
☐ Medical Records Coding	☐ Home Health/Hospice	☐ AOR/Surgery	
☐ Medical Terminology	☐ IV Certified	☐ Orthopedic	☐ Spreadsheet:
☐ Switchboard	☐ Labor & Delivery	☐ Phlebotomist	☐ Windows
☐ Typing wpm:	☐ Long Term Care Facility	☐ Physicians Office	☐ Word Processing:
☐ 10-key	☐ Med/Surg	☐ Skilled Nursing Facility	
☐ Other:	☐ MRI	☐ Sports Medicine	☐ Other:
☐	☐ Nursery	☐ Telemetry	
☐	☐ Substance Abuse	☐ Other:	

List any special skills or qualifications you may have including internships, association affiliations, certificates, volunteer work, etc.

EMPLOYMENT EXPERIENCE **(List all places of employment including temporary, full-time, part-time employment & volunteer activities, within the last 20 years.)** Begin with most recent or current employer. List multiple jobs with same employer separately.

PRESENT EMPLOYER (OR LAST JOB)

Employer (Current or most recent)	Address:		Phone Number(s):	Dates Employed From: Month / Year
	City, State, Zip:			To: Month / Year
Job Title:	Dates in this Job Title: From	To:	Describe job duties:	
Supervisor	Month / Year	Month / Year		
Work Status (FT, PT, OC, Prn)	Hourly Rate/Salary			
	Start	Current/Final		
	$	$	If currently employed, may we contact this employer? ☐ No ☐ Yes	
Reason for Leaving::				

PREVIOUS EMPLOYMENT (OR LAST JOB)

Employer	Address:		Phone Number(s):	Dates Employed From: Month / Year
	City, State, Zip:			To: Month / Year
Job Title:	Dates in this Job Title: From	To:	Describe job duties:	
Supervisor	Month / Year	Month / Year		
Work Status (FT, PT, OC, Prn)	Hourly Rate/Salary			
	Start	Current/Final		
	$	$		
Reason for Leaving::				
Employer (Current or most recent)	Address:		Phone Number(s):	Dates Employed From: Month / Year
	City, State, Zip:			To: Month / Year
Job Title:	Dates in this Job Title: From	To:	Describe job duties:	
Supervisor	Month / Year	Month / Year		
Work Status (FT, PT, OC, Prn)	Hourly Rate/Salary			
	Start	Current/Final		
	$	$		
Reason for Leaving::				
Employer (Current or most recent)	Address:		Phone Number(s):	Dates Employed From: Month / Year
	City, State, Zip:			To: Month / Year
Job Title:	Dates in this Job Title: From	To:	Describe job duties:	
Supervisor	Month / Year	Month / Year		
Work Status (FT, PT, OC, Prn)	Hourly Rate/Salary			
	Start	Current/Final		
	$	$		
Reason for Leaving::				

*Request additional work history sheets if needed

Account for all periods of one month or more in the last 3 years in which you were not employed:

How were you referred to ReDiscover?

☐ Employee (Name):_____
☐ School (Name):_____
☐ Recruiting Agency_____
☐ Government Agency:_____
☐ Walk-in ☐ Recruitment Fair
☐ Newspaper ad (Name of Paper):_____
☐ Internet
☐ Another Person Is this a relative? ☐ No ☐ Yes
If yes, Name:_____
☐ Community Organization (Specify):_____
☐ Job Opportunities Bulletin:_____
☐ Campus Visit (where):_____
☐ Professional Journal:_____
☐ Other:_____

PROFESSIONAL REFERENCES

Name	Agency	Phone/Email
Name	Agency	Phone/Email
Name	Agency	Phone/Email

Applicant acknowledgements
(PLEASE READ CAREFULLY)

I understand that if I have made any false statements in the application form, or if I omitted any material information, that such false statement(s) or omissions may disqualify me from further consideration for employment, or may result in my termination if I have already been employed.

I understand that any offer of employment that may be made to me is contingent upon passing a post offer physical examination, which will include a drug screen and background checks (Family Care Registry).

In consideration of my employment, I agree to conform to the rules & regulations of the employer. My employment can be terminated with or without cause, and with or without notice at any time. I also understand & agree that due to the type of services rendered by this institution, I may be required to work a schedule or in an area other than that for which I may be initially hired.

I understand that if I am required to be registered and/or licensed I will notify my supervisor immediately if any investigation, probation, limitation or cancellation of my registration and/or license occurs. I understand that if I fail to do so, my employment may be terminated.

I certify that I have listed all convictions, no matter how old, on this application and I specifically certify that I have never been convicted of or plead guilty or no contest to a class A or B felony, and that my name is not now and has never been placed on any State's Department of Social Services' employee disqualification list of those individuals who have been found to have abused or neglected elderly or handicapped patients or residents. I further certify that I have never been convicted of the crimes of "patient, resident or client abuse or neglect" or of "furnishing unfit food to patients or client", or of failing to report abuse or neglect in a mental health facility or treatment facility.

I certify that I am not currently suspended, debarred or otherwise excluded from Medicare/Medicaid/Champus/Champra programs. I further agree that I will inform my employer if I become suspended or proposed for exclusion from these federal programs.

In the event that I am not hired, I understand my application will be active for a period of 6 months.

I hereby give my permission and authorize representatives of ReDiscover to investigate any or all of the statements I have made in this application for employment. I understand that such authorization will allow representatives of ReDiscover to contact any or all of the employers I have listed and I hereby authorize those employers to supply the requested information. I hereby release those employers from any liability arising out for the release from such information.

_____ _____
Applicant Signature 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.

REGISTRATION TYPE (Check all that apply)

- ☐ 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.

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

Complete this column only if 'Long Term Care/Personal Care' selected from left.

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 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: REDISCOVER

EMPLOYER ADDRESS: 1550 NE RICE ROAD

EMPLOYER CITY	STATE	ZIP
LEE'S SUMMIT	MO	64086

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
(816) 347-3080	DEDEI SCISLOWICZ	HR GENERALIST

☐ No Employer, because I am a(n):

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

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.)
➤	

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, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Family Care Safety Registry may contact you to request a personal email address if one is not provided.

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.

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.

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, ATTN: Fee Receipts, 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 contact information. *Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO 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. 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).

ReDiscover

ReDiscover is an equal opportunity employer and committed to a diverse work force. We are required to report the numbers of people who apply at our corporation by ethnic group, sex, veteran, disabled, and over forty status. Your cooperation will be appreciated in completing the following form. **This information will be used only for reporting purposes as legislated by Federal and State regulations.** Submission of this information is **voluntary**; and will not be used in making an employment decision.

APPLICANT VOLUNTARY SELF-IDENTIFICATION RECORD

(Please Print)

Last Name:_____ **First Name**:_____ Middle Initial:_____

SSN:_____ Phone #: Home:_____ Cell:_____

Address:_____ City:_____ State:_____ ZIP:_____

Job Title(s) of
Position(s) Applying for:_____

Type of Employment Preferred:

☐ Full-Time ☐ Part-Time ☐ Temporary ☐ On-Call (PRN)

Shift Preferred:

☐ Days ☐ Evenings ☐ Nights

Gender:

☐ Male ☐ Female

Over Forty (Years of Age):

☐ No ☐ Yes

Race/Ethnic Identification (check one)

☐ **Hispanic or Latino**- A person of Cuban; Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

If you did not check "Hispanic or Latino" above, please select one of the following race/ethnic identifications.

☐ **White** (Not Hispanic or Latino) A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American** (Not Hispanic or Latino) –A person having origins in any of the black racial groups of Africa

☐ **Native Hawaiian or Other Pacific Islander** (Not Hispanic or Latino) A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian** (Not Hispanic or Latino) -A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native** (Not Hispanic or Latino) A person having origins in any of the original Peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ Two or More Races (Not Hispanic or Latino) All persons who Identify with more than one of the above live races.

VETERAN/DISABLED STATUS (Please check)

☐ **Not Applicable**

☐ **Veteran of the Vietnam ERA**· A person who (1) served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1964 and May 7, 1975, and was discharged or released there from with other than a Dishonorable Discharge, or (2) was discharged released from active duty for a service-connected disability if any such active duty was performed between August 5, 1964 and May 7, 1975.

☐ **Disabled Veteran** • A person entitled to disability compensation under laws administered by the Veterans Administration for a disability rated at 30 percent or more, or a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.

☐ **Disabled Individual** • A person who (1) has a physical or mental impairment which substantially limits one or more of such person's major life activities; (2) has a record of such impairment; or (3) is regarded as having such an impairment.

Pride
People Respecting the Individual Differences of Everyone
Celebrating Our Diversity

_____
Applicant Signature:

_____
Date