AGENCY EMPLOYEE APPLICATION

Equal access to programs. Services employment is available to all persons. Those applicants requiring accommodation for the application and or interview process should contact a representative of the Personnel Department.

Name:_____
Last First Middle

Date of application:_____/_____/_____Date available:_____/_____/_____

Address: _____

City:_____State:_____Zip Code: _____

E-Mail Address_____

Primary Phone #:_____ Secondary Phone #:_____

Date of Birth:_____/_____/_____ SSN: _____

Professional Status: ☐RN ☐LPN ☐HHA ☐CNA ☐Non-Medical Aide ☐OTHER

State License/Certification #:_____Expiration:_____/___/_____

I am Interested in ☐Full-Time ☐Part-Time

I have worked for All Saints Home Care. ☐Yes ☐No If Yes When: _____

The best time to call you: _____

Name of person who referred you (if applicable): _____

HIGHEST LEVEL of EDUCATION

☐High School ☐Vo Tech ☐College/University ☐Other_____

Graduate:
☐Yes ☐No

_____
School Name Major

All Saints
Home Care

AGENCY EMPLOYEE APPLICATION
EMPLOYMENT HISTORY

List your previous employment history starting with the most recent including military experience.

Employer _____ May We Contact ☐ Yes ☐ No

From: To: Telephone:

Job Title: Address:

Employer _____ May We Contact ☐ Yes ☐ No

From: To: Telephone:

Job Title: Address:

PROFESSIONAL REFERENCES

List at least three (3) persons, other than relatives, who have knowledge of your professional standards and performance.

Name	Mailing Address	Phone

In the interest of efficiency and expediency, for myself and the agency, I hereby give my permission to phone my listed references to obtain the data needed by the agency, on which to base their decision concerning my employability. I have provided correct telephone numbers to facilitate the process.

☐ I Agree

AGENCY EMPLOYEE APPLICATION

FELONY DISCLOSURE

I understand that not all felony records prevent me from being employed by All Saints Home Care, Inc. It is essential that the agency know of any past or pending convictions. If I have failed to disclose any past or pending convictions I will be terminated when this information becomes available.

☐ I Understand

Offense **Year**

_____

_____

_____

All Employees must pass the state mandated background checks prior to working or claiming any hours. Any Employee with offenses listed on the state's Prohibited Offenses List will be ineligible to work.

My signature below indicates that the information submitted is true and correct to my knowledge and that I am aware that any falsification of information on this application for employment may be grounds for immediate termination.

Applicant Signature Date

AGENCY EMPLOYEE APPLICATION

IMPORTANT INSTRUCTIONS:
Background Checks

The next 4 forms are for release to perform background checks. It is very important that they are filled out completely and correctly. **Any forms not completed or that are incorrect will be returned to the worker for recompletion. This will delay the time it takes to receive the background clearance.**

As of 1/1/2017 all personal care attendants (PCA) must pass the state mandated background checks prior to working or claiming any hours. Any personal care attendant must not have any offenses listed on the state's Prohibited Offenses List.

Any PCA with offenses on this list will be ineligible to work for the client. This list can be found at

https://kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/health-occupations-credentialing/hcbs-criminal-record-check/criminal-record-check-prohibited-offenses-in-statute-number-order.pdf?sfvrsn=1fc107ee_6

No hours will be paid, and no time will be accepted until all the above checks are cleared and the office has informed the worker that they are eligible to work and have issued the Authenticare ID

HEALTH OCCUPATIONS CREDENTIALING
612 SOUTH KANSAS AVE, TOPEKA, KS 66603-3404

CRIMINAL RECORD CHECK REQUEST FORM

FACILITY NAME: All Saints Home Care, INC. **FACILITY I D #** A087081

ADDRESS: 3425 W. Central **CITY**: Wichita **STATE** : KS

ZIP CODE:67203

Applicant information: **ALL REQUESTED INFORMATION MUST BE PROVIDED** or the form will not be processed.

Last Name: | First Name: | Middle Name | Suffix (Jr, Sr, etc)

Other Names Ever Used:

Last Name:

Last Name: **

** List additional names on back. Check here if more on back. ☐

Social Security Number | Date of Birth | Sex | Race

One of the following **must** be selected
A - Asian or Pacific Islander
B - Black
I - Native American/Alaskan Native
W - White

Address | Post Office Box # (if applicable)

City | State | County | Zip Code

Home Phone | Work Phone

Certificate # (if applicable)

Job Classification: Determine the correct job classification for the applicant and Insert the three letter abbreviation in the box.

Activities Staff	**ACS**	Food Service Worker	**FSW**	Medical Records Staff	**MRS**
Administrator	**ADM**	Home Health Aide	**HHA**	Operator	**OPR**
Business and Administrative	**BAS**	Home Health Aide Trainee	**HHT**	Paid Driver	**DRV**
Certified Medication Aide	**CMA**	Housekeeping	**HSK**	Paid Nutrition Assistant	**PNA**5
Certified Nurse Aide	**CNA**	Human Resources Staff	**HRS**	Personnel Staff	**PER**
Nurse Aide Trainee	**NAT**	Laundry Workers	**LDW**	Restorative Ade	**RSA**
Chaplain	**CHN**	Maintenance Worker	**MTW**	Social Service Designee	**SSD**
Clerical Staff	**CLS**	Marketing Staff	**MKT**	Volunteer Coordinator	**VLC**
				Wellness Staff	**WEL**

FORM C - REV - 7/12

Completed by | Date

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/21

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Human Resources **Phone** 316-755-1076

Agency name All Saints Home Care, Inc.

Agency mailing address 3425 W Central Ave. Wichita, KS 67207

Email address: Will return via Encrypted email unless marked otherwise Tawnie@allsaintshomecare.com

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☒ **Yes** ☐ **No**

Signature: _____ **Date**: _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations
Adult Abuse Registry
500 SW Van Buren St
Topeka, Kansas 66603
(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	**For Official Use Only: Mark in this area if CLEARED**

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Child Abuse and Neglect Central Registry
P.O. Box 2637 ● Topeka, KS 66601 ● DCF.CentralRegistry@ks.gov

Release of Information

Complete form by printing legibly in ink. Fee of $10.00 per Release of Information form may be required prior to processing.

All releases and fees are to be sent to the address or email listed above (see below for specifics)

CONFIDENTIALITY: ***Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.***

Contact Person: Tawnie Hartley
Agency/Org.: All Saints Home Care
Phone #: 316 755 1076
Address: 3425 W Central
Email: Tawnie@allsaintshomecare.com
City/State/Zip: Wichita, KS 67203

Return Results by: ☐ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Postal mail only.***	
☐ *Online Payment**	www.dcf.ks.gov – 'Online DCF Payments' bottom of page. Payment Portal. Submit receipt with ROI form(s).	
☒ *Pre-Pay Account**	Agency/Org. has Pre-Pay Account.	FEIN: 48-1233986
☐ *Mentoring Account**	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
☐ *Exempt**	No fee for State government agencies (Sub-contracting agencies not included).	

*Release of Information forms may be submitted via email to DCF.CentralRegistry@ks.gov

APPLICANT: *Instructions: PRINT CLEARLY. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☐ *Yes* ☐ *No*

This organization/person/agency may check my information each year I am employed or associated with them: ☐ *Yes* ☐ *No*

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. 'N/A' if none used.): _____

DATE OF BIRTH: _____ **RACE:** _____

SOCIAL SECURITY #: _____ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

DCF ONLY:

MATCH		CLEARED
This applicant is listed in the Child Abuse/Neglect Central Registry. *Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.* (see attached document for more info.)		

Kansas 3rd Party Consent Form

I hereby certify that my name is _____
(First Name) (Middle Initial) (Last Name)

Address _____
(Street Address) (City) (State) (Zip)

Birthdate _____ Telephone Number _____
(MMDDYYYY)

Driver's License Number _____

Tag Number _____

Vehicle Identification Number_____

I hereby authorize All Saints Home Care, INC.
(First Name) (Middle Initial) (Last Name)

to obtain my vehicle registration and/or driver's license record information including my personal information on those records.

_____ _____
Signature (Date)