

HEALTH OCCUPATIONS CREDENTIALING
834 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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.**

One of the following **must** be selected

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security Number	Date of Birth	Sex	Race	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	PNA5
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

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

OBI 1011
 9/2018
 Page 1 OF 1

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)

<input type="checkbox"/> <i>Fee included</i>	\$10 per request. Check, Money Order (payable to DCF) or cash. Postal mail only.	
<input type="checkbox"/> <i>Online Payment*</i>	www.dcf.ks.gov – ‘Online DCF Payments’ bottom of page. Payment Portal. Submit receipt with ROI form(s).	
<input checked="" type="checkbox"/> <i>Pre-Pay Account*</i>	Agency/Org. has Pre-Pay Account.	FEIN: 48-1233986
<input type="checkbox"/> <i>Mentoring Account*</i>	As listed in the Kansas Mentors' Partner Directory. http://mentorkansas.org/Find-a-Program	
<input type="checkbox"/> <i>Exempt*</i>	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	
<i>This applicant is listed in the Child Abuse/Neglect Central Registry.</i> <i>Per KSA 65-504 and 65-516 this person prohibited from working, residing, or volunteering in a licensed child care home or facility.</i> (see attached document for more info.)	

CLEARED

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)