NORTHEAST INDEPENDENT LIVING SERVICES

YOUR DISABILITY RESOURCE CENTER

VOLUNTEER PACKET

CHECKLIST

- Complete Volunteer Application
- Complete FCSR Background Screening Form
- Pay for background screening cost
- Obtain orientation with supervisor (review of policy and procedure manual)
- Sign Statement of Acknowledgement
- Sign Statement of Confidentiality

NorthEast Independent Living Services

Your DisABILITY Resource Center

Volunteer Application

Application Date: ___/___/____

Applicant Name: _____ Primary Telephone: _____
First Middle Last

Stress Address: _____

Mailing Address: _____

Have you ever volunteered for us in the past? Yes No If yes, when? ___/___/___ to ___/___/____

Position Desired: _____ When will you be available to begin? ____/____/_____

How many hours a week would you like to volunteer? _____

What days/hours are you available? _____

List any special training or skills: _____

_____

Do you have any criminal convictions, findings of guilt, pleas of guilty, and/or pleas of nolo contendere except minor traffic violations? Yes No

If yes, please explain: _____

_____

Do you consent to a Family Care Safety Registry background screening? Yes No

List any memberships you are currently serving with or have served in the past:

Organization Name: _____ Date(s) of membership: _____

Organization Name: _____ Date(s) of membership: _____

Organization Name: _____ Date(s) of membership: _____

List your three most current places of employment:

Business Name: _____ Date(s) of employment: _____

Business Name: _____ Date(s) of employment: _____

Business Name: _____ Date(s) of employment: _____

The information I have provided in this application is true and correct to the best of my knowledge. If approved to volunteer, any misstatement or omission of fact on this application may result in my dismissal. I understand that acceptance of an agreement to volunteer does not create a contractual obligation upon the employer to continue to allow me to volunteer in the future.

Applicant Signature: _____ Date: ____/_____/_____

Family Care Safety Registry Instructions

If you can check to see if you are already registered by going to:

https://webapp02.dhss.mo.gov/bsees/IsAPersonRegistered.aspx?ID=2&sk=SK191070248

and entering your personal information. If it says you are already registered, you will not need to pay the $12.00 registration fee but you are required to still complete the Worker Registration Form in this packet.

On the Worker Registration Form, volunteers should complete the following blanks:

- **Social Security Number**
- **Personal Information**
- **Contact Information**
- **Signature of Applicant**
- **Date of Signature**

Volunteers should enclose a check or money order in the amount of $12.00 made payable to Missouri Department of Health and Senior Services, if they are not already registered.

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 **$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.)

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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 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.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

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, 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).

NORTHEAST INDEPENDENT LIVING SERVICES

YOUR DISABILITY RESOURCE CENTER

Statement of Acknowledgement

I acknowledge that the Policy and Procedure Manual describes important information about NorthEast Independent Living Services (NEILS). I understand that I should consult the Executive Director regarding any question not answered in the manual.

CHECK ONE:

☐ I have entered into my employment relationship with NEILS voluntarily and acknowledge that there is not a specified length of employment. Accordingly, I or NEILS may terminate the relationship at will, with or without cause, at any time so long as there is no violation of applicable federal or state law.

☐ I have entered into a volunteer role with NEILS voluntarily and acknowledge that there is not a specified length of volunteer activity. Accordingly, I or NEILS may terminate the relationship at will, with or without cause.

Since the information, benefits, policies, and procedures described herein are subject to change, I acknowledge that revisions to the Policy and Procedure Manual may occur. All such changes will be communicated through official notices and I understand that revised information may supersede, modify, or eliminate existing policies and/or procedures.

I have reviewed the Policies and Procedures Manual, and I hereby acknowledge and understand that it is my responsibility to read and comply with the policies contained in this manual.

_____ ____/____/_____

Printed Name Date

_____

Signature

NORTHEAST INDEPENDENT LIVING SERVICES

YOUR DISABILITY RESOURCE CENTER

Statement of Confidentiality

I hereby affirm I, _____, will forever regard as, and maintain strictly confidential and secret information, and except to those authorized and bound by the confidentiality agreement, will not disclose to any person, firm, entity, or otherwise publish information managed by or under the control of NorthEast Independent Living Services.

I will notify NorthEast Independent Living Services' Executive Director immediately, not to exceed twenty-four (24) hours, of any disclosure or suspected disclosure, whether mine or that of another individual, whether intentional or unintentional.

I understand and agree that maintaining the confidentiality of NorthEast Independent Living Services is an essential responsibility and a violation of this confidentiality statement will result in a material breach of agreement between myself and NorthEast Independent Living Services. I further acknowledge and understand that the unauthorized access to, modification of, deletion of, or disclosure of information violates individual rights of privacy and/or constitutes a criminal act.

Distribution and/or reproduction of any record or information outside the intended and approved use is strictly prohibited. Illegal access or misuse of this information is punishable by fine and/or imprisonment.

By signing below, I acknowledge that I have read, understand, and agree to the above Statement of Confidentiality.

_____ ____/____/_____

Printed Name Date