



OZARKS AREA COMMUNITY ACTION CORPORATION
An Equal Opportunity Employer

INSTRUCTIONS FOR EMPLOYMENT APPLICATION

1. Applications are only accepted if an advertised position is available. Our positions are posted on the OACAC website at: www.oacac-caa.org under employment info, advertised in the Springfield News Leader, on CareerBuilders.com or in the local county newspaper. If a position is available in a county center, the address for that location will be listed in the advertisement. Application and current resume must be received in our office by the deadline or the application will not be considered.
2. The Application for Employment is Form #1 and is three pages long. It must be filled out entirely and submitted with a current resume or it will not be considered. There is an additional page for employment history if needed. **Do not use “see resume”.**
3. If you are applying for a Head Start position you must complete the Declaration Form for Prospective Employees for Head Start Program following the application. **You must also complete the Missouri Family Care Safety Registry Worker Registration Form.**
4. The Employment Application, additional employment forms, if necessary, and current resume can be brought into our office in person, mailed or faxed to:

OACAC
“Attn” HR Director
215 S. Barnes
Springfield, MO 65802
FAX TO: 417-873-3352

NOTE: APPLICATION, ADDITIONAL EMPLOYMENT FORMS, IF NECESSARY, AND CURRENT RESUME MUST BE RECEIVED IN OUR OFFICE BY THE DEADLINE OR THE APPLICATION WILL NOT BE CONSIDERED.



APPLICATION FOR EMPLOYMENT

OZARKS AREA COMMUNITY ACTION CORPORATION

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General Information

<ul style="list-style-type: none"> Follow instructions carefully Provide detail—DO NOT use “see resume” Print or type neatly 		<ul style="list-style-type: none"> Completely fill out or application will not be considered Check for errors & signature before submitting Position (s) applied for must be indicated on form 	
Position (s) applying for:		County/Location:	
Date of application:			
Name (Last, First, Middle Initial)		Telephone:	
		Cell Phone:	
Social Security Number			
Mailing Address		City	
		State	Zip
Have you ever been employed by OACAC before or volunteered? (If yes, please indicate position and date).			
Is any member of your family presently working for OACAC in any capacity? (If yes, please state name and position).			
Have you ever been convicted of a crime other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain). <i>Convictions are not an absolute bar to employment but will be considered in relationship to the job requirements.</i>			
Do you have a valid Missouri driver’s license? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="text"/> State <input type="text"/> Expiration Date		CDL w/passenger endorsement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Education and/or Skills

Did you graduate from high school or receive a GED Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are you at least 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Name and Location (college, business, nursing, vocational, other)	Number of Hours	Field of Study		Did you graduate?	Diploma or Degree earned
		Major	Minor		
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Check computer experience: _____ Excel _____ Word _____ Desktop Publisher _____ Access _____ Other _____					
List clerical/phone/office skills: _____ Secondary Language: _____					
List work experience with young children and ages: _____					
List any social work/case management/volunteer work experience _____					
License/Certification	State	Profession	License/Certification Number	Expiration Date	
Military Service from <input type="text"/> To <input type="text"/> Branch of Service					

- Start with your current or last job—include armed forces service and self-employment information.
- Any change of job title under the same employer should be considered a separate position.

May we contact your current employer for a reference?

What date would you be available for work?

Employment History
 (Provide detail—do not use “see resume”)

1	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
2	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
3	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
4	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
5	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
6	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			

Monthly Salary	Reason for Leaving		
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Name: _____

Position (s) applying for: _____

Other Qualifications: Describe in detail the part of your experience or education which you believe to be pertinent to meeting the qualifications for and performing the duties of this position. Describe any job related experiences obtained through civic, volunteering or community work.

REFERENCES

List below the names of three persons not related to you, who can provide work-related references and whom you have known for at least one year.

References

<p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p># of Years Known: _____</p> <p>Occupation: _____</p>	<p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p># of Years Known: _____</p> <p>Occupation: _____</p>	<p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p># of Years Known: _____</p> <p>Occupation: _____</p>
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APPLICANT'S STATEMENT

Read carefully before signing.

I authorize investigation of all statements made on my resume, application, or those made during an interview for job selection. Such investigation may include checks for criminal record, driving record, child abuse/neglect record, drug and alcohol testing, references, and past/current employers. I authorize my former employers to furnish and release all information relating to my employment, such as the quality of my work, dates of employment, and reason for leaving. In addition, I release OACAC, any former employers and all references listed above from any and all claims, demands or liabilities arising out of or related to such investigation or disclosure.

I understand that all information will be considered in determining eligibility for employment and that a false or dishonest answer to any question will be grounds for an ineligible rating for employment with OACAC or for dismissal after employment. All findings related to the employment investigation will be preserved in the applicant's file.

I understand that this application does not constitute an agreement or contract for employment for any specified period or definite duration.

Date

Applicant's Signature

Authorization & Signature

Name:
Position (s) applying for:

7	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			
Monthly Salary		Reason for Leaving	

8	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			
Monthly Salary		Reason for Leaving	

9	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			
Monthly Salary		Reason for Leaving	

10	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			
Monthly Salary		Reason for Leaving	

11	Employer	Phone	Supervisor's Name
Type of Business		Address	
Your Job Title		Dates Employed (Mo/Day/Yr)	
Duties:			
Monthly Salary		Reason for Leaving	



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DECLARATION FORM FOR PROSPECTIVE EMPLOYEES
HEAD START PROGRAM

Name (Last, First, Middle Initial)

Federal policies require that Head Start agencies require all prospective employees to sign a declaration prior to employment which lists:

1. All pending and prior criminal arrests and charges related to child sexual abuse and their disposition
2. Convictions related to other forms of child abuse and/or neglect
3. All convictions of violent felonies

The declaration may exclude:

- Any offense, other than any offense related to child abuse and/or child sexual abuse or violent felonies committed before the prospective employee's 18th birthday, which was finally adjudicated in a juvenile court or under a youth offender law
- Any conviction for which the record has been expunged under Federal or State law
- Any conviction set aside under the Federal Youth Correction Act or similar State authority

Note that individuals who declare, through this form, that they have been arrested, charged with or convicted of any of the offenses listed above are not automatically disqualified from being hired. OACAC must review each case to assess the relevance of an arrest, charge or conviction to a hiring decision.

Please provide your signature on the appropriate category below:

I have not been arrested, charged, and/or convicted on one or more of the three (3) types of offenses listed above.

Signature: _____ Date: _____

I have been arrested, charged, and/or convicted on one or more of the three (3) types of offenses listed above. Please attach information listing the offense (s), the date (s) of the arrest, charge, and/or conviction, and other relevant information.

Signature: _____ Date: _____

For use by Head Start agencies to comply with 45 CFR Part 1301, Subpart D. Head Start Grants Administration, Personnel Policies, Section 1301.31 (c) and (d).



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.

WORKER REGISTRATION

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.)

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/DPW/DDD/Other

A one-time registration fee of **\$10.00** applies to all categories except Foster Parents. Foster Parents must list the agency or 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.)

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (if applicable.)
OTHER NAMES USED (If applicable. Include other last names, other first names, nicknames.)		DATE OF BIRTH (mm/dd/yyyy) / /	GENDER <input type="checkbox"/> M <input type="checkbox"/> F

CONTACT INFORMATION

STREET ADDRESS (Must be different from Employer Street Address.)

ADDRESS LINE 2 OR PO BOX (If applicable. This line of the address must reflect where you receive your mail.)

CITY	STATE	ZIP CODE	COUNTY
TELEPHONE () -	EMAIL (Optional)	COUNTRY (Complete only if U.S. territory or outside U.S.)	

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:	<input type="checkbox"/> No Employer, because I am a(n):
EMPLOYER NAME	<input type="checkbox"/> Adoptive Parent
EMPLOYER STREET ADDRESS	<input type="checkbox"/> Foster Parent/Family Member
EMPLOYER CITY	<input type="checkbox"/> Home Child Care Provider
STATE	<input type="checkbox"/> Private Pay/Private Duty
ZIP	<input type="checkbox"/> Student
EMPLOYER TELEPHONE () -	<input type="checkbox"/> Volunteer
EMPLOYER CONTACT NAME	<input type="checkbox"/> Other (Explain: _____)
EMPLOYER CONTACT TITLE	

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 requestor 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 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, any post office box or other identifying mailing address information, 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 requestors 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 requestor, 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).