Our House My House KC, Inc.

6528 Raytown Rd
Suite C
Raytown, MO 64133

"Where Caring Comes Naturally."

Maylon D. Williams-Sims
Director
office: 816-737-8628
fax: 816-737-1064

Dear Applicant:

I would like to take the time to thank you for your interest in working with Our House. Originally the name of the agency was "My House". My brother, the late Rick Williams, founded "My House" in Kansas City, in April of 1997. His passion was to open Individualized Supported Living homes (or ISLs) for adults with developmental disabilities. Rick worked as a professional in Health and Human Services beginning in 1985 and strongly believed in helping others to lead an active, fulfilled and productive life. When he became ill, I took over his dream and fully intend to keep it going.

In June of 2001, "My House" opened its first ISL in Boonville, MO, under the guidance of the Central Missouri Regional Center. In November of 2003, the agency became incorporated, which necessitated a name change; "My House" became Our House of Kansas City, Inc. In December of 2003, Our House was presented with the "Provider of the Year Award" from the Central Missouri Regional Center. In March 2012, the agency once again necessitated a name change due to a new business structure. All employees of Our House My House are part of the mission that began with Rick and continues today, providing our individuals with exceptional caring and support.

The following is a list of things that I will need, along with your application:

1. Copy of your Driver's License
2. Copy of your Social Security Card
3. Copy of your proof of auto insurance
4. Copy of your Medication Aide Certificate
5. Copy of your First Aid/CPR cards
6. High School Diploma/Transcript/ or GED
7. Any other certificates from training that you have completed in this field. For example: Mandt, Positive Behavior Support, Abuse and Neglect, etc.
8. <u>If you have not registered in the Family Care Safety Registry, then you will need to complete the Caregiver Background Screening form.</u>
9. Make sure that you complete all of the information for <u>two</u> work-related reference checks.

You will be contacted after all of your hiring forms are turned in and after all background checks are completed. Thank you.

Sincerely,

Maylon Williams
Director

OUR HOUSE MY HOUSE KC, INC. "Where Caring Comes Naturally"
6528 Raytown Rd, Ste C * Raytown, MO 64133 * Office: 816-737-8628 * Fax: 816-737-1064

APPLICATION

APPLICANT INSTRUCTIONS: If you need help filling out this application form or for any phase of the employment process, please notify the person that gave you the form, and every effort will be made to accommodate your needs in a reasonable amount of time. Please write clearly. Illegible applications will not be processed.

Today's Date: _____ Name: _____

Date Of Birth: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Address: _____

APPLICANT NOTE: This application is intended for use in evaluating your qualifications for employment. Please answer all appropriate questions completely and accurately. False or misleading statements during the interview and on this form are grounds for terminating the application process or, if discovered after employment, terminating employment. Documents must be provided to verify training experience and educational qualifications. All qualified applicants will receive consideration without discrimination because of sex, marital status, race, age, creed, national origin or the presence of disabilities. Drug testing is required prior to employment.

AVAILABILITY

For which position are you applying? ☐ Direct Support ☐ Volunteer Other: _____

What date can you start? _____ What status would you prefer? ☐ Full-time ☐ Part-time ☐ PRN

For which schedules are you available? ☐ 7a – 3p ☐ 3p – 11p ☐ 11p – 7a ☐ weekends

JOB-RELATED SKILLS

☐ Yes ☐ No Do you have a valid driver's license?

☐ Yes ☐ No Have you had any moving violations? Describe: _____

☐ Yes ☐ No Do you have a current First Aid certificate? Exp. Date: _____

☐ Yes ☐ No Do you have a current CPR certificate? Exp. Date: _____

☐ Yes ☐ No Are you a certified Med Aide I? Date of certification: _____

☐ Yes ☐ No Have you been given a job description?

☐ Yes ☐ No Can you perform the requirements of this job with or without reasonable accommodations?

SECURITY

Will any of these background checks reveal charges on your record? If yes to any, explain in the Comments.

☐ Yes ☐ No State of Missouri Criminal Background Check?

☐ Yes ☐ No Division of Family Services?

☐ Yes ☐ No Division of Aging Disqualification List?

☐ Yes ☐ No Department of Mental Health Disqualification List?

☐ Yes ☐ No Have you been convicted of, or served time for any felony in the past 7 years?

COMMENTS

PREVIOUS EMPLOYERS

Please Note: Your application will not be considered unless every question in this section is answered. Since we will make every effort to contact previous employers, the correct phone numbers of past employers is critical. Ask for a phone book if you need to.

MOST RECENT EMPLOYER ☐yes ☐no Are you currently working for this employer? ☐yes ☐no May we contact?

Company Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

Dates Employed: From _____ to _____ Salary: _____

Duties: _____

Reason for Leaving: _____

Company Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

Dates Employed: From _____ to _____ Salary: _____

Duties: _____

Reason for Leaving: _____

Company Name: _____ Phone: _____

City: _____ State: _____ Fax: _____

Dates Employed: From _____ to _____ Salary: _____

Duties: _____

Reason for Leaving: _____

REFERENCES

Include only individuals familiar with your work ability. Do not include relatives.

NAME	ADDRESS/PHONE	YEARS KNOWN/RELATIONSHIP
1.		
2.		

EDUCATION

Circle highest grade completed: 8 9 10 11 12 13 14 15 16 16+

NAME	CITY/STATE	GRADUATE?	DEGREE?
HIGH SCHOOL			
COLLEGE			
OTHER			

CERTIFICATION AND RELEASE

I certify that I have read and understand the applicant notes on this form, and that all my answers and statements are complete and true. I understand that any false statement or omission of information disqualifies me from employment, or can result in discharge after employed. I authorize Our House to verify any of this information. I authorize all former employers, persons, schools, Department of Health, Department of Mental Health, Division of Family Services, Division of Aging, and law enforcement authorities to release any information concerning my background and hereby release any said persons from any liability for any damage whatsoever for issuing this information.

Signature: _____ Date: _____

OUR HOUSE MY HOUSE DIRECT SUPPORT JOB DESCRIPTION

HEALTH AND SAFETY:

1	**Direct support staff are responsible for 24-hour supervision of all individuals, unless time alone is approved in the person's plan. Do not leave individuals unattended, and be totally attentive with those who are line of sight and/or have restrictions.**
2	Monitor the health of the individuals- be alert to and respond to sickness, medication reactions, excessive seizures, PRN meds running out, first aid supplies needed.
3	Implement first aid/CPR as needed. Follow emergency procedures. Take individual to the ER when necessary.
4	Pass medications at correct times. Document correctly and in a timely manner.
5	Monitor seizures and document if appropriate.
6	Take individuals to doctor appointments if asked. Bring back paperwork.
7	Monitor the safety of the home – do fire/weather drills, monitor hot water, keep meds/ chemicals locked and safe.
8	Complete event, addendum and/or med error reports as needed for accidents, illness, etc.

TEACHING- SOCIAL, ACADEMIC, & INDEPENDENT LIVING SKILLS:

1	Monitor and assist with personal hygiene DAILY. Assist individuals with clipping fingernails and toenails as needed. Assist with shaving as needed.
2	Teach social skills and correct lack of manners.
3	Address/confront socially inappropriate behaviors when they are small. Be firm, but do not be unkind. Be consistent.
4	Look for learning opportunities in the course of a normal day. Teach a new skill, teach good manners, teach relationship building, etc.
5	Offer and teach making choices, problem solving, and consumer rights.
6	Know the person's IHP, especially their supports and goals/outcomes.
7	Teach IHP programs as they are written. Document as written on the goal. Inform QDDP/QMP of problems with the programs.
8	Complete all IHP documentation, prepare for monthly reviews, and maintain progress notes.
9	Teach independence by encouraging individuals to try to accomplish tasks on their own. Staff should provide the least amount of assistance needed for the individuals to safely manage their daily tasks, homes, and their lives.

HOME MANAGEMENT:

1	Teach cleaning skills and assist individuals with all house cleaning and laundry.
2	Prepare healthy meals or cook. Support individuals who may wish to assist staff with cooking. Encourage individuals with cooking goals to be involved.
3	Report maintenance needs to the landlord or safety coordinator. Follow up with your house manager as needed.
4	Inform house manager of problems, behaviors, home needs, etc.

ACTIVITIES:

1	Always monitor individuals in the community, and take the travel first aid kit, and medical info folder.
2	Provide transportation for individuals to attend work, day programs, activities, etc. Record and turn in mileage and activities.
3	Assist individuals to go out into the community and become a part of the community they reside in. (See list of free activities posted for individuals with limited funds in the office.)
4	Take individuals shopping as assigned or needed.
5	Take individuals to any Special Olympics sports, ACED classes, Jackson County dances, or any activity they are participating in.
6	Schedule with individuals to use their free time in a variety of ways. Assist individuals to play cards and board games, read, do arts and crafts, work on hobbies. Do not depend on video games or the TV to keep individuals occupied. Participate with them and motivate them to have fun.

PROFESSIONALISM:

1	Know and follow agency policies and procedures.
2	Attend IHPs when available and attend mandatory staff or house meetings. Give input to the team on how to assist the individual to be successful.
3	Do not call house managers excessively. Try to call from 9a to 5p when possible. Know when to call and when to handle the problem yourself. Use or call the on-call phone when needed.
4	Take initiative. Organize activities, find resources, don't be afraid to try something new.
5	Complete all required documentation: med records, IHP goals, progress notes, monthly reviews, activities, fire/weather drills, event reports, etc.
6	Attend meetings and trainings as assigned. Present a professional image.

I have read and understood the job description for *Our House My House KC, Inc.* and I agree to follow the job duties as listed.

Signed: _____ Date: _____

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).

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. 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.)

— —

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
OUR HOUSE MY HOUSE KC, INC.

EMPLOYER ADDRESS
6528 RAYTOWN RD., SUITE C

EMPLOYER CITY	STATE	ZIP
RAYTOWN	MO	64133

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
(816) 737 - 8628	HALISA BRADSHAW	QMP

☐ 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.)
➤	- -

Note to Applicant: *This form will be faxed or mailed to the references that you indicate. Two references will be checked and must be work related, not friends or family. Please complete all information so that the form is ready to be sent and your application process is not delayed.*

REFERENCE CHECK

CERTIFICATION AND RELEASE

I authorize Our House My House to verify any application information I have listed. I authorize all former employers, persons, schools, etc. to release any information concerning my background and hereby release any said persons from any liability for any damage whatsoever for issuing this information.

Signature: _____ Date: _____

EMPLOYEE, PLEASE PRINT TO COMPLETE THE FOLLOWING:

YOUR NAME: _____

PLACE EMPLOYED: _____ FAX #: _____

CONTACT PERSON: _____ PHONE:

_____

ADDRESS: _____

_____

DATES OF EMPLOYMENT: _____ TO _____

POSITION HELD: _____

REFERENCE, PLEASE COMPLETE THE FOLLOWING:

1. Are the dates of employment correct?	YES NO
Comments:	

PERSON COMPLETING FORM:

NAME: _____ DATE: _____

Note to Applicant: *This form will be faxed or mailed to the references that you indicate. Two references will be checked and must be work related, not friends or family. Please complete all information so that the form is ready to be sent and your application process is not delayed.*

REFERENCE CHECK

CERTIFICATION AND RELEASE

I authorize Our House My House to verify any application information I have listed. I authorize all former employers, persons, schools, etc. to release any information concerning my background and hereby release any said persons from any liability for any damage whatsoever for issuing this information.

Signature: _____ Date: _____

EMPLOYEE, PLEASE PRINT TO COMPLETE THE FOLLOWING:

YOUR NAME: _____

PLACE EMPLOYED: _____ FAX #: _____

CONTACT PERSON: _____ PHONE:

_____

ADDRESS: _____

_____

DATES OF EMPLOYMENT: _____ TO _____

POSITION HELD: _____

REFERENCE, PLEASE COMPLETE THE FOLLOWING:

2. Are the dates of employment correct?	YES NO
Comments:	

PERSON COMPLETING FORM:

NAME: _____ DATE: _____