



COMMISSION ON AGING FAMILY SERVICES, INC.
111 Virginia Avenue
Petersburg, West Virginia 26847
(304) 257-1666
Tamara Alt, Executive Director

APPLICATION FOR EMPLOYMENT

FEDERAL AND STATE LAWS PROHIBIT DISCRIMINATION IN EMPLOYMENT BECAUSE OF SEX, AGE, RACE, COLOR, RELIGIOUS CREED, MARTIAL STATUS, NATIONAL ORIGIN, ANCESTRY, CITIZENSHIP, LIABILITY FOR SERVICE IN THE ARMED FORCES OF THE UNITED STATES OR DISABILITY OR ANY OTHER PROTECTED CLASSIFICATION.

Date _____

PERSONAL INFORMATION

Name _____
Last First Middle Initial

Present Address _____
Street City State Zip Code

Telephone _____ & _____
Home Cell

IF UNDER 18 YEARS OF AGE, DO YOU HAVE A WORK PERMIT? Yes _____ No _____

Valid Driver's License: Yes _____ No _____

Vehicle with current registration and Insurance: Yes _____ No _____

HAVE YOU HAD FINGER PRINTING DONE IN THE LAST 3 YEARS Yes _____ No _____

CURRENT CPR & 1ST AID: YES _____ NO _____ EXPIRATION DATE: _____

ARE YOU A U.S. CITIZEN OR AN ALIEN WHO HAS THE LEGAL RIGHT TO REMAIN AND WORK IN THE U.S.? (YOU WILL BE REQUIRED TO FURNISH PROOF OF LAWFUL WORK STATUS IF YOU ARE EXTENDED A JOB OFFER).

Yes _____ No _____

HAVE YOU EVER BEEN CONVICTED OF A CRIME?

Yes _____ No _____

IF SO, PLEASE DESCRIBE FULLY THE CRIMINAL CONVICTION(S). LISTING THE NATURE OF THE OFFENSE, THE DATE OF THE OFFENSE, AND YOUR REHABILITATION SINCE THE CONVICTION(S) (A EMPLOYMENT.)

EMPLOYMENT DESIRED

POSITION(S) APPLIED FOR: _____

DATE YOU CAN START: _____

HAVE YOU EVER WORKED FOR THIS COMPANY BEFORE:

When: _____ Supervisor: _____

Reason for leaving: _____

EDUCATION

HIGHEST GRADE COMPLETED: _____

NAME OF SCHOOL LAST ATTENDED: _____

LICENSE, VOCATIONAL OR TRADE TRAINING: _____

EMPLOYMENT HISTORY

LIST BELOW YOUR WORK EXPERIENCE (STARTING WITH YOUR PRESENT OR MOST RECENT EMPLOYER) FOR THE LAST FIVE YEARS OR YOUR LAST THREE EMPLOYERS, WHICHEVER WILL PROVIDE US WITH THE FREATEST INFORMATION ABOUT YOU. USE THE REVERSE SIDE OF THE APPLICATION FORM IF YOU NEED ADDITIONAL SPACE. PLEASE ACCOUN FOR ALL PERIODS OF UNEMPLOYMENT IN THIS SECTION.

<u>Dates of Employment</u>	<u>Name and Address of Employer</u>	<u>Name of Supervisor</u>	<u>Job Title</u>	<u>Salary</u>
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From: _____

To: _____

BRIEFLY DESCRIBE YOUR JOB DUTIES AND WORK EXPERIENCE: _____

REASON FOR LEAVING: _____

MAY WE CONTACT YOUR PRESENT EMPLOYER AT THIS TIME? Yes _____ No _____

<u>Dates of Employment</u>	<u>Name and Address of Employer</u>	<u>Name of Supervisor</u>	<u>Job Title</u>	<u>Salary</u>
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From: _____

To: _____

BRIEFLY DESCRIBE YOUR JOB DUTIES AND WORK EXPERIENCE: _____

REASON FOR LEAVING: _____

MAY WE CONTACT YOUR PRESENT EMPLOYER AT THIS TIME? Yes _____ No _____

Dates of Employment **Name and Address of Employer** **Name of Supervisor** **Job Title** **Salary**

From: _____

To: _____

BRIEFLY DESCRIBE YOUR JOB DUTIES AND WORK EXPERIENCE: _____

REASON FOR LEAVING: _____

MAY WE CONTACT YOUR PRESENT EMPLOYER AT THIS TIME? Yes _____ No _____

CENTRAL ABUSE REGISTRY

“All service providers in the State of West Virginia are subject to provisions of law creating a central abuse registry. Any person providing services for compensation to children or to incapacitated adults receiving behavioral health services, who is convicted of a misdemeanor or felony offense constituting abuse, neglect or misappropriation of property of a child or an incapacitated adult or an adult receiving behavioral health services, is subject to listing on the central abuse registry. The fact that a person is listed on the registry may be disclosed in specific instances provided by law. Listing on the registry may limit future employment opportunities, including opportunities for employment with residential care facilities, day care centers and home care agencies. It is the policy of the Commission on Aging Family Services, Inc. to promptly report all suspected instances of abuse, neglect, or misappropriation of property to the proper authorities and to cooperate fully in the prosecution of these offenses.”

PRE-EMPLOYMENT DRUG SCREEN AUTHORIZATION

If offered employment by the Commission on Aging Family Services, Inc. you will be required to take a drug test prior to beginning employment. Failure to consent to the test or failure of the test will result in your offer of employment being rescinded.

STATEMENT AND AUTHORIZATION

I understand that employment with Commission on Aging Family Services, Inc. is at-will, meaning that I or COAFS may terminate my employment at any time, or for any reason consistent with applicable state or federal law.

I authorize Commission on Aging Family Services, Inc. and/or its appointed representatives or agents to conduct a thorough background investigation of my work and personal history, and verify all data given on this application and during interviews. In addition, I authorize COAFS and/or its appointed representatives or agents to conduct a drug test on me. I hereby release Commission on Aging Family Services, Inc. and/or its appointed representatives or agents, from any liability that might result from such an investigation or drug test. I authorize all individuals, schools and firms named to provide any requested information and release them from all liability for providing the requested information.

I understand this application will be active for a period of 90 days; after that time, if I wish to be considered for employment, I must submit a new application. I certify that all the statements in this completed application are true and understand that any falsification or willful omission shall be sufficient cause for dismissal or refusal to hire.

Signature of Applicant: _____ **Date Signed:** _____



Blue Ink

**Authorization and Release for Protective Services
Record Checks for Providers and
Agency Personnel for Employment Purposes**

Please complete and sign below. The form must be legible, and all fields must be filled out COMPLETELY.

Name (Print full name. Do not use initials): _____
(First Name) (Middle Name) (Last Name)

Birth Date: _____ Social Security Number: _____

Current Home Address (Give location address, as well as P.O. Box address and County):

Please list all addresses or the county(s) and state(s) of all previous residences:

List maiden name, all aliases, or names known by Print full name(s); do not use initials:

Name of Agency who will receive results/verification of the protective services check:

Agency Address: _____

Agency Contact Information: _____

Type of Agency:

- Child Placing Agency (Potential employee)
- Residential Provider Agency (Including Psychiatric Residential (PRTF)/Intermediate Care Facilities (ICF))
- Emergency Shelter
- Child Care/Head Start
- Other _____

Certification:

I certify that I have not committed any act of child/adult abuse or neglect, as determined by a civil or criminal proceeding or through an investigation by the WV Department of Health and Human Resources or through any like agency of any other state or country, or that I am currently being investigated for such except as stated below:

Authorization:

I authorize the WV Department of Health and Human Resources to conduct a background check on me which includes a search of Child Protective Services records, Adult Protective Services records, Youth Services records, Institutional Investigation Unit records and foster care provider records maintained by the Department. I authorize the Department to inform the person or agency named on the front of this form of the results of the background check, including any history I have had with Social Services. I understand that if I have an open CPS/APS investigation the protective service check will not be completed; the open investigation will be documented on the form and returned to the requesting agency. **I understand that a positive history of maltreatment in any West Virginia Department of Health and Human Resources protective services record will affect my becoming a foster care placement provider or employee of an agency that provides foster care services. I understand that any involvement I have had with the WVDHHR as a client or foster care provider will be evaluated and may also affect my becoming a foster care placement provider or foster care agency employee.** I release the WVDHHR and/or its agents in providing information pursuant to this authorization from any and all liabilities, claims or lawsuits.

Signature: _____ **Date:** _____

DHHR Office Use Only

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- No record of substantiated maltreatment was found.
- Records indicate that maltreatment occurred by the individual.
- Records indicate current open CPS, and/or APS investigation.

IF THIS CLIENT HAS ANY QUESTIONS OR NEEDS TO OBTAIN INVESTIGATION RECORDS, THEY MUST CONTACT THE FOLLOWING COUNTY:

COUNTY: _____

INTAKE/CASE #: _____

(DHHR Stamp or Signature of Authorized Individual)

(Date)



WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

SELF-DISCLOSURE APPLICATION AND CONSENT FORM

PART I

I, the below-named applicant, understand that this form cannot be completed until an offer of employment is made. The offer of employment is made pending the results of the investigation of registries and a fingerprint-based background check. I understand that refusal to complete Parts I, II, and III of this form constitutes my rejection of the employment offer.

I, the below-named applicant, swear/affirm, that the information contained within this application is true and correct to the best of my knowledge.

Applicant Last Name: _____ First Name: _____ MI: _____ Generation (ex. Jr., II): _____

Clearly answer truthfully YES or NO to the following questions:

Table with 6 rows of questions and 2 columns: Yes, No

NOTE: If any questions 1-6 listed above are answered YES, a brief letter of explanation by the applicant must accompany this form. Failure to provide explanations could result in disqualification.

PART II

Consent for Investigation for Employment Purposes and Acknowledgement of Receipt of Notice

I hereby authorize the Department of Health and Human Resources (DHHR) to conduct an investigation including, but not limited to, registry and state and federal fingerprint-based background checks, into information contained in this application. I understand that my fingerprints will be retained by the West Virginia State Police for the purpose of RapBack services during my employment in a WVCARES covered provider. Furthermore, I understand that the falsification of any information contained within this application constitutes false swearing and is an excluding act under the fitness determination process being conducted by DHHR.

I, _____, acknowledge receipt of the information contained in the Notice to All Applicants. (Applicant's printed name)

Signature of Applicant: _____ Date: _____



WV CARES

West Virginia Clearance for Access: Registry and Employment Screening

SELF DISCLOSURE APPLICATION AND CONSENT FORM

PART III

Applicant Last Name: _____ First Name: _____ MI: _____ Generation (ex. Jr., II): _____

Gov't Issued ID Number/Expiration: _____ State of Issue: _____ Type of ID: _____

Gender: Male _____ Female _____ Race: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Hair Color: Brown Blonde Bald Eye Color: Blue Hazel Brown
 Black Gray Other Red Black Other
 Red White Green Gray

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Place of Birth (City & State): _____ Citizenship: _____

Current Mailing Address: _____ County: _____

Current Physical Address: _____ County: _____

List all cities and states (outside of WV) where you have lived within the past 5 years and provide approximate dates:

List all cities and states (outside of WV) where you have worked within the past 5 years and provide approximate dates:

List all names and aliases you have used formally and informally (Include maiden names, married names, nicknames, and any other name used or known as):

For Office Use Only (This form expires 60 days after the date of the signature in Part II):

I affirm that I have compared the government issued identification presented by the applicant.

Signature: _____ Date: _____

Printed Name: _____ Position: _____