Learning Opportunities/Quality Works, Inc.
Application for Employment

LOQW, Inc.

Please print and answer all questions. If one does not apply, insert or check "n/a". If additional space is required to adequately answer a question, please indicate by an asterisk (*) and identify the supplemental information on a separate sheet.

When reading and answering these questions, please keep in mind that none of the questions are intended to imply limitations, preferences, or discrimination based on age, sex, marital status, race, creed, color, national origin, or existence of any sensory, mental, or physical disability that does not interfere with the performance of the position for which you are applying. EEO Employer/Vet/Disabled

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LOQW Office Locations:
(Please check all locations you are interested in.)

☐ 201 North Locust St
Monroe City, MO 63456
(573) 735-4282

Visit us online at:
www.loqw.com

☐ 215 East McPherson
Kirksville, MO 63501
(660) 627-1749

☐ 111 South 10th St.
Hannibal, MO 63401
(573) 221-5991

☐ 645 Clinic Road
Hannibal, MO 63401
(573) 719-3487

☐ 204 Crescent Dr.
Macon, MO 63552
(660) 385-6325

☐ 316 S. 2nd St.
Shelbina, MO 63468
(573) 588-7919

Position applying for: _____ Date: _____

Personal Background

Name_____ _____-____-_____
Last First Middle Initial Social Security Number

Address_____ Phone (_____)_____

City_____ State_____ Zip_____

Date available for work_____ Salary requirement $_____per_____

Email Address: _____

Have you the legal right to work in the U.S.? Yes ☐ No ☐
Have you ever been convicted of a felony? Yes ☐ No ☐
If yes, explain (A conviction will not necessarily disqualify you from the job.) _____
_____
_____

I prefer: ☐ Part-time ☐ Full-time
Will you work overtime if asked? Yes ☐ No ☐

Hours available for work: Mon. _____ Weds. _____ Fri. _____

Tues. _____ Thurs. _____ Sat. _____ Sun. _____

Emergency contact: Name_____
Phone: _____ Relationship_____

Employment History

Company Name	Telephone ( )
Address	Employed (Month & Year)
Name of supervisor	Weekly Pay (Starting & Ending)
Title & description of work	Reason for leaving

Company Name	Telephone ( )
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Company Name	Telephone ( )
Address	Employed (Month & Year)
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Skills

Foreign languages: (Proficiency to speak, read or write) _____

Typing Yes ☐ (_____ wpm) No ☐

List other special skills, technical or professional knowledge, or use of machines: _____

_____

_____

_____

_____

_____

_____

Organizations

Please tell us about any clubs, groups or organizations you belong to:

1. Organization:_____ Activities/Position:_____
2. Organization:_____ Activities/Position:_____
3. Organization:_____ Activities/Position:_____

Education & Training

School Attended:	Name	City	State	Circle last year completed	Major area of study	Grade point average	Degree
High School				1 2 3 4			
Junior College				1 2 3 4			
University				1 2 3 4			
Grad School				1 2 3 4			
Trade School				1 2 3 4			
Other				1 2 3 4			

To support your application list any additional training or seminars: _____

_____

_____

_____

_____

List any licenses, certificates, publications or professional achievements: _____

_____

_____

_____

_____

How were you referred to us? ☐ Current Employee _____ ☐ Former Employee _____

☐ Missouri Career Center ☐ Help Wanted Flyer ☐ Walk-in ☐ Local Newspaper Ad

☐ Jobs.MO.gov ☐ www.loqw.com ☐ Radio Announcement ☐ Other _____

Please read the following before signing this application

1. I declare that my answers to the questions in this application are true to the best of my knowledge and belief. I understand that misrepresentation or omission of facts called for is cause for dismissal.

2. I understand that any false or incorrect statement or omission of a fact on this application or during the applicant screening process shall result in rejection of my application or my dismissal.

3. I understand that the consideration of my application does not constitute an obligation to offer employment. I authorize investigation of all statement contained in this application.

I have read and understand the above.

_____

Applicant Signature Date

LOQW, Inc.

Support • Advocacy • Connection to Resources

LOQW is an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, sex, age, status as a protected veteran, among other things, or status as a qualified individual with disability.

Learning Opportunities/Quality Works, Inc.
is proud to be a United Way agency.

LOQW, INC. ASPIRES TO EXCELLENCE. VISIT US AT WWW.LOQW.COM FOR MORE INFORMATION ABOUT OUR CARF ACCREDITATION & OUR COMMITMENT TO QUALITY.

CARF International accreditation demonstrates a program's quality, transparency, and commitment to the satisfaction of the persons served. CARF International is an independent, nonprofit accreditor of health and human services. For more information about CARF International, the standards, or the accreditation process, visit www.carf.org.

Learning Opportunities/Quality Works, Inc.

REFERENCE FORM (PROFESSIONAL REFERENCES REQUIRED)

LOQW, Inc.

To Be Completed By Applicant: **Applicant's Name:** _____

Reference Name, Organization, & Title:

Reference Address: Reference Phone: Reference email:

I authorize the following information to be released to Learning Opportunities/Quality Works, Inc. at P.O. Box 254 in Monroe City, Mo 63456. You may also contact 573-735-4282, ext. 114, with questions.

_____ _____

Applicant Signature Date

To Be Completed By Reference or Person Making Reference Call:

1. Was the applicant an employee of your company? ☐ Yes ☐ No
   If yes, what position did they hold?
2. What types of duties did this individual perform while working for you?
3. What were the applicant's strengths?
4. What were the applicant's weaknesses?
5. How would you describe this individual's attendance? How many times have they called in to work in the past year? Are they on time to work or have they been tardy frequently?
6. How would you characterize their problem solving skills? Would you say the individual makes decisions independently, seeks help with decision making and problem solving, or doesn't make good decision?
7. Would you rehire this applicant? ☐ Yes ☐ No
8. Do you have any areas of concern?
9. Is there anything else you would like to add?

☐ Completed by Reference ☐ Completed via Telephone by Human Resources

Signature of Reference/Person Making Reference Call: _____

Learning Opportunities/Quality Works, Inc.

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☐ Completed by Reference ☐ Completed via Telephone by Human Resources

Signature of Reference/Person Making Reference Call: _____

LOQW, Inc.

Equal Employment Opportunity Self-Disclosure Form

Learning Opportunities/Quality Works, Inc. is an equal opportunity employer. In order to meet this commitment, it is necessary to collect information concerning applicants. Your response to this request is voluntary and refusal to provide it will not subject you to any adverse treatment. Data is used to fulfill reporting requirements, in accordance with our Affirmative Action Program.

Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Desired Position: _____

Ethnicity:

☐ **Hispanic or Latino** – a person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture origin, regardless of race.

☐ **Not Hispanic or Latino**

Race: (select one or more)

☐ **American Indian or Alaskan Native** – a person having origins in any of the original peoples of North and South America (including Central America), who maintains cultural identification through tribal affiliation or community recognition.

☐ **Black or African American** – a person having origins in any of the Black racial groups of Africa.

☐ **Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, for example, China, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Native Hawaiian or Other Pacific Islander** – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White** – a person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

LOQW, Inc.

Voluntary Self-Disclosure of Veteran Status

Learning Opportunities/Quality Works, Inc. is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

A "disabled veteran" is one of the following:

- A veteran of the U.S. military, ground, naval, or air service who is entitled to c compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; **or**
- a person who was discharged or released from active duty because of a service-connected disability.

A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA – the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at **1-800-4-USA-DOL.**

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. Your response to this request is voluntary and refusal to provide it will not subject you to any adverse treatment.

As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

Name: _____

☐ I IDENTIFY AS ONE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

☐ I AM NOT A PROTECTED VETERAN

LOQW, Inc.

Pre-Offer Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)

☐ NO, I DON'T HAVE A DISABILITY

☐ I DON'T WISH TO ANSWER

_____ _____

Your Name Today's Date

LOQW, Inc.

Pre-Offer Voluntary Self-Identification of Disability

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

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 **$13.00** 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.

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

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 (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: Learning Opportunities/Quality Works, Inc.

EMPLOYER ADDRESS: 201 North Locust Street, P. O. Box 254

EMPLOYER CITY	STATE	ZIP
Monroe City	MO	63456

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
(573) 735 - 4282	Cynthia Johns	Human Resources

☐ 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.)
➤	- -

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 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. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

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).