New Hire/Orientation Packet Checklist

Employee Name:_____

Home:_____

All Orientation Packet Pages Signed/Dated_____

Copy of ID (Front and Back)_____

Physical Clearance:_____

TB Clearance:_____

Diploma, GED, or Graded Comp Test:_____

3 References:_____

Resume:_____

Application PT. II_____

Direct Deposit/Bank Card_____

Signed up for RR Training_____

Signed up for CPR/FA:_____

Sign on Bonus (If Applicable) _____

Entered in CHIP (If Applicable)_____

Home Supervisor Signature_____

Program Coordinator Signature_____

Created: 12/23

CENTRAL STATE COMMUNITY SERVICES, INC.
NEW HIRE REQUEST
FOR CRIMINAL HISTORY RECORD CHECK
BY NAME OR OTHER IDENTIFIERS

Requesting Agency: Central State Community Services, Inc.
2603 W. Wackerly St. Suite 201
Midland, MI 48640

Facility Name:

Please Print

First Name: _____ Middle Name: _____ Last Name: _____
(Spell Out Middle Name)

Date of Birth: ____/_____/_____ State and/ or Country: _____
MM / DD / YYYY of Birth

Any Other Names used: (Married, Maiden, Nickname) _____

Country of Citizenship: _____ Height: _____ Weight:_____ Hair Color:_____ Eye Color:_____

Gender: Male / Female (Circle One) Race: Asian / Black / Hispanic / Native American / Pacific Islander / White (Circle One)

Social Security Number: _____/_____/_____ Driver's License Number: _____
/ ## /

Address:# and Street_____ Apt/Lot:_____ Phone Number:(____)_____

City:_____State:_____ZipCode:_____ County:_____Email Address: _____

*** Has this applicant worked in long-term care prior to April 1, 2006 _____Yes _____ No (Check One)**

****Did this applicant continuously reside in Michigan within the last 12 months_____Yes_____No (Check One)**

Interviewer signature ---------- Please print Name_____

Occupation Applying For: Direct Care Worker / LPN / RN/ CNA (Circle One)
Professional License Number (Required if applicant has ever had a license):_____
(For use when applying as an LPN/RN/CNA)

Supervisors:
1. You must have a signed Long Term Care Workforce Background Check Application Form from the employee before submitting this form.
2. Send all completed forms to the office for processing.
3. Applicant is not eligible for hire until you receive authorization from the office.

For Office Use Only:
Signature of Authorized Representative:_____Date:_____

Central State Community Services
Competency Test for DSP

Name: _____ Date: _____ Home:_____

Score: _____/100 (Must be an 80% to pass).

Scenario:

1. How would you handle a situation where an individual refuses assistance with personal hygiene?
    a. Use a degrading tone to convince the individual to do what is needed.
    b. Respect the individual's wishes and offer assistance later.
    c. Make sure everyone in the company knows that the individual is noncompliant. and refuses assistance.
    d. Ignore the individual for the rest of the day.

Communication/ Interpersonal Skills:

2. How do you establish effective communication with a non-verbal individual?
    a. Use gestures and body language.
    b. Speak very, very loud not worrying about embarrassing the individual.
    c. Ignore the individual for the rest of the day.
    d. Make someone else work with the individual.
3. What is a crucial aspect of communicating with an individual's family members?
    a. Provide as much information as possible because knowledge is power and privacy doesn't matter.
    b. Avoiding family involvement in caregiving decisions by shutting down any communication.
    c. Keeping them informed about the individual's well-being while ensuring to follow the privacy guidelines.
    d. Discouraging family visits to maintain professional boundaries.

Safety and Emergency Response:

4. How can you prevent accidents and injuries in an individual's home?
    a. Avoid discussing safety concerns with the client.
    b. Regularly assess the home for potential hazards.
    c. Ignore minor safety issues.
    d. Only address safety concerns during scheduled inspections.

Individual Independence and Empowerment:

5. How do you encourage an individual to participate in activities of daily living?
    a. Do tasks for the individual to save time.
    b. Encourage the individual to do as much as they can do independently.
    c. Assume the individual prefers assistance in all activities. Discourage independence to avoid potential risks.

CENTRAL STATE COMMUNITY SERVICES, INC.

EMPLOYEE REFERENCE FORM

REGARDING: _____

PERSON CONTACTED: _____

PHONE NUMBER: _____

RELATIONSHIP: _____YEARS KNOWN: ___

STRENGTHS: _____

PROBLEMS OR WEAKNESSES: _____

LEADERSHIP ABILITY: _____

DEPENDABILITY: _____

WHAT TRAITS DOES THIS PERSON HAVE THAT WOULD MAKE THEM SUCCESSUL IN WORKING WITH PEOPLE WITH DISABILITIES?

_____

Email Address: _____ Phone #:_____

_____
SIGNATURE DATE

* Please return this form to hrteam@cscsmi.com or fax it to (989) 631-8760.

CENTRAL STATE COMMUNITY SERVICES, INC.

EMPLOYEE REFERENCE FORM

REGARDING: _____

PERSON CONTACTED: _____

PHONE NUMBER: _____

RELATIONSHIP: _____YEARS KNOWN: ___

STRENGTHS: _____

PROBLEMS OR WEAKNESSES: _____

LEADERSHIP ABILITY: _____

DEPENDABILITY: _____

WHAT TRAITS DOES THIS PERSON HAVE THAT WOULD MAKE THEM SUCCESSUL IN WORKING WITH PEOPLE WITH DISABILITIES?

_____

Email Address: _____ Phone #:_____

_____
SIGNATURE DATE

* Please return this form to hrteam@cscsmi.com or fax it to (989) 631-8760.

CENTRAL STATE COMMUNITY SERVICES, INC.

EMPLOYEE REFERENCE FORM

REGARDING: _____

PERSON CONTACTED: _____

PHONE NUMBER: _____

RELATIONSHIP: _____YEARS KNOWN: ___

STRENGTHS: _____

PROBLEMS OR WEAKNESSES: _____

LEADERSHIP ABILITY: _____

DEPENDABILITY: _____

WHAT TRAITS DOES THIS PERSON HAVE THAT WOULD MAKE THEM SUCCESSUL IN WORKING WITH PEOPLE WITH DISABILITIES?

_____

Email Address: _____ Phone #:_____

_____
SIGNATURE DATE

* Please return this form to hrteam@cscsmi.com or fax it to (989) 631-8760.

CENTRAL STATE COMMUNITY SERVICES, INC.
Application for Employment - Community Support Specialist
Part II
Rev. 8/21, 3/26/10, 1/09

We are an equal opportunity employer. CSCS, Inc., subscribes to a policy of equal admission opportunities. There shall be no discrimination against a recipient or an applicant for services based on gender, pregnancy, race, color, religion, national origin, citizenship, mental or physical disability, military service, veteran status, political affiliation, familial and marital status, age, sexual orientation, gender expression, height, weight, or genetic information.

If you are a person with a handicap, you may request any needed reasonable accommodation to participate in the application process or interview process. This request should be made in advance so that we can make an accommodation.

We will not discriminate against a person with a covered disability under the Americans with Disabilities Act in regard to employment practices, or terms, conditions, and privileges of employment.

PERSONAL INFORMATION

DATE_____

NAME_____SOCIAL SECURITY #_____
Last First Middle

DRIVERS LICENSE #_____ STATE ISSUED_____

PRESENT ADDRESS_____
Street City State Zip

PHONE # ( ) _____ ALTERNATE PHONE #_____

SPECIAL QUESTIONS

1. If the position you applied for requires driving, do you currently have a valid and unrestricted driver's license? □ Yes □ No

2. Are you 18 years of age or older? □ Yes □ No

3. Can you perform the duties of the job in which you wish to be employed, with or without accommodation? □ Yes □ No

4. We are licensed to provide adult foster care for 24 hours a day, 7 days a week, and 52 weeks a year. Working any shift and overtime hours is expected for continued employment. Are you able to meet this requirement? □ Yes □ No

5. Do you have any commitments or responsibilities that could prevent regular attendance at work? □ Yes □ No If yes, explain: _____

6. This job may require overtime or excessive hours. Can you meet this requirement? □ Yes □ No

7. Have you ever been convicted of a misdemeanor? □ Yes □ No
(Note: Affirmative answers to this question may not automatically preclude you from consideration for employment.) If yes, please explain. _____
_____

8. Have you ever been convicted of a felony? □ Yes □ No
(Note: Affirmative answers to this question may not automatically preclude you from consideration for employment.) If yes, please explain. _____
_____

9. Do you currently have any misdemeanor charges pending against you? □ Yes □ No

10. Do you currently have any felony charges pending against you? □ Yes □ No

11. Have you ever been administratively determined by a federal, state or local governmental agency to have committed abuse or neglect? □ Yes □ No
If yes, when, where, and nature of the case. _____
_____

12. Are you on a court-supervised probation or parole? □ Yes □ No
If yes, please explain. _____
_____

13. Have charges ever been substantiated against you in a Department of Commerce, Department of Consumer and Industry Services, Department of Human Services Adult Foster Care Licensing investigation or the Office of Recipient Rights? □ Yes □ No
If yes, please explain. (Attach additional pages if necessary):
_____

14. Have you ever worked for this company? □ Yes □ No

15. Have you ever worked for this company under a different name? □ Yes □ No

16. Is there any additional information relative to change of name, use of an assumed name or nick-name necessary to enable a check of your work record? □ Yes □ No

If yes, please explain.: _____

17. Have you ever applied to this company before? □ Yes □ No
If yes, when and where? _____

18. Please indicate the names of any relatives or friends already employed by this employer:
_____

19. Were you referred by a current employee to work with us? If yes, name of employee:
_____

20. Can you verify U.S. citizenship or your right to work in the U.S.? □ Yes □ No

21. If not a U.S. citizen, do you have the legal right to remain permanently in the U.S.? □ Yes □ No

The position you are applying for today is for a Community Support Specialist Position in a group home for adults with developmental disabilities, mental illnesses &/or other impairments.

22. What is your personal philosophy of discipline?

_____

_____

_____

_____

23. Have you ever worked with adults with developmental disabilities, mental illnesses &/or other impairments? □ Yes □ No (If no, skip this section and go to "Employment Desired Section)

If yes, complete the following:

24. What is your professional philosophy of discipline?

_____

_____

_____

_____

25. What techniques have you used in the past to encourage appropriate behavior when dealing with adults with developmental disabilities, mental illnesses &/or other impairments?

_____

_____

_____

_____

26. What techniques have you used in the past to discourage inappropriate behavior when dealing with adults with developmental disabilities, mental illnesses &/or other impairments?

_____

_____

_____

EMPLOYMENT DESIRED

Date you can start_____

Are you employed now? □ Yes □ No

If so may we inquire of your present employer? □ Yes □ No

EDUCATION

High School attended_____

City and State_____Graduate? _____ GED? _____

ADDITIONAL EDUCATION

School and address	Degree	Major	G.P.A.

FORMER EMPLOYERS

(List below the last four employers, starting with the most recent first)

Date Month and year	Name and address of Employer	hourly wage	Position	Reason for Leaving
From_____ To_____				
From_____ To_____				
From_____ To_____				
From_____ To_____				

PERSONAL REFERENCES

1. _____

2._____

3._____

4._____

Name Address Phone

PROFESSIONAL

1._____

2._____

3._____

4._____

Name Address Phone

I hereby give you my permission to contact the above employers, references and educational institutions to verify items I listed above. I hereby release Central State Community Services, Inc., and the above referenced organizations, reference persons and employers from all claims, liability and damages that may result from furnishing the information to us. I expressly and fully waive all written notice from all prior employers. I consent to releasing any information relating to my job performance which is documented in my personnel file.

I also understand that because of the nature of my job and licensing requirements, I hereby consent to the release of this application or portions of this application to representatives of the Department Commerce/Department of Consumer and Industry Services, Family Independence Agency, Department of Community Health, and the local Community Mental Health agencies, or other governmental or private agencies for all licensing or investigator purposes and to verify information I have listed in this job application. I hereby release Central State Community Services, Inc., the Department of Commerce, Family Independence Agency, Department of Community Health, the local Community Mental Health Agencies and other various governmental or private agencies from all claims, liability, and damages that may result from furnishing the information to you.

I further specifically waive written notice and agree to the divulging of any disciplinary reports, letters of reprimand or other disciplinary action by all prior employers, and hereby release my prior employers from all claims, liability and damages that may result from furnishing the information to you.
Signature_____Date_____

I further understand that any dishonest, false or incomplete answers on this application or in any subsequent interviews are grounds for immediate dismissal.

Signature_____Date_____

This application will be kept current for six months. You need to complete another application to be reconsidered after this date.

EMPLOYMENT AGREEMENT In consideration of my employment, I agree to conform to the rules and regulations of central State Community Services, Inc. My employment and compensation can be terminated at-will with or without cause and with or without notice at any time, at the sole discretion of Central State Community Services, Inc. or myself. I agree that no one other than the Executive Director has any authority to enter into any agreement or contract for any specified period of time, or to make any agreement contrary to the foregoing. I further agree that no one other than the Executive Director has any authority to make any changes to this Employment Agreement in writing and signed by the Executive Director and me.

_____

Employee Signature Date

_____

Employer Representative Date

POSITION DESCRIPTION
Direct Support Professional

The position for which you are applying is a Community Support Specialist position. Inasmuch, Central State Community Services, Inc., would like to provide you with a brief (NOT ALL INCLUSIVE) description of possible job duties.

1. You will be working in the homes of adults who have developmental disabilities and mental illnesses.
2. Some of the individuals may have secondary disabilities (example: speech, vision, hearing, ambulation and/or behavioral limitations).
3. You may be called on to provide hand over hand assistance with very personal hygiene issues (bathing, toileting, diapering, and tooth brushing).
4. You may be called upon to assist individuals with daily household routines (laundry, meal planning, cooking, washing dishes, cleaning bathrooms, vacuuming and dusting).
5. You may be called upon to lift, transfer, and when necessary to prevent injury, to physically manage an individual. As such, you must be physically able to lift at least 90 pounds.
6. You may be called on to transport individuals to work, therapies, or leisure activities using public transportation or agency vehicles. Inasmuch, your driving record could affect your suitability for employment.
7. You may be called upon to participate with individuals in a wide range of leisure activities (swimming, bicycling, movies, concerts, picnics, amusement parks, etc.).
8. You may be called upon to implement treatments such as tube feedings, breathing treatments, etc.
9. Inasmuch as some of those individuals may be medically frail. You may have to deal with death and dying in the workplace.

Additionally, Central State Community Services, Inc., would like to make you aware of practices that may effect your decision to pursue employment.

1. All employees must complete in-house training and observation before any work hours will be scheduled. These training sessions must be taken seriously and are considered part of your job. You will be required to sign the In-House Training Checklist and to document the time spent on training and observation on the time sheet provided by the Home Supervisor. You will be paid your regular rate of pay for these hours. You will be required to sign in on the time sheets upon the start of your shift, training, &/or staff meeting/in-service. At the conclusion of your shift, training, &/or staff meeting/in-service you are required to sign out. It is your responsibility to document all hours correctly, your signature on the time sheet indicates you have accurately documented all hours worked correctly. Falsifying of <u>ANY</u> documentation is grounds for immediate dismissal.
2. All employees are required to attend and successfully complete the Department of Community Mental Health Group Home Curriculum Training with-in the specified time frame. All trainings you attend will be scheduled by the Home Supervisor. You will be paid your hourly wage for attendance in these classes.

3. All employees are required to attend monthly “client progress review” or “staff meetings”. You will be paid your regular hourly wage for attendance.

4. Attendance at scheduled trainings or staff meetings is mandatory and is a requirement for your continued employment. Exceptions are made on in extreme cases requiring prior notification and the approval of a Program Coordinator.

5. Only full-time employees who are regularly scheduled for 30 hours a week or more AND who have successfully complete 14 weeks of employment are eligible for health insurance enrollment.

6. All shifts are awake shifts in order to provide for the safe supervision of the people we serve. It is the policy of Central State Community Services, Inc. that sleeping on duty is strictly prohibited. This prohibition includes lying your head or your body down or reclining with eyes closed and the use of blankets and pillows while reclining and/or closing eyes. Violations of this policy are grounds for immediate dismissal.

7. You are not eligible for paid time off from scheduled workdays until you have completed one full year of employment. If you are unable to fulfill your work responsibility, YOU MUST make arrangements for a trained person to cover your shift.

8. You earn sick/personal and vacation time during your first year of employment.

9. The home is in operation 365 days a year. You will be expected to work on those days at your regular rate of pay. Time and half wages are paid for specified holidays.

10. You will be paid Bi-Weekly.

11. Work schedules are posted in the home you are assigned to. However, you remain an employee of CSCS, Inc., and you are expected to work at any location assigned to you. Work schedules are written based on the needs of the home and the individuals residing In those homes. Consistency in the number of hours scheduled is dependant upon funded hourly allotments from the Department of Mental Health.

12. Central State Community Services, Inc., is an at will employer.

_____ _____

Signature of Employee Date

_____ _____

Signature of Interviewer Date

DO NOT WRITE BELOW THIS LINE

INTERVIEWED BY_____

DATE_____

APPLICANT HIRED: □ YES □ NO POSITION: _____ HOME:_____

Writing skills: □ Poor □ Average □ Above average

Handwriting: □ Illegible □ Legible

Answer: □ Agrees with corporate philosophy □ Does not agree

RECOMMENDATIONS: (use scoring system below) Rating scale (check one)

□ 1. CMH/DCH trained with experience.
□ 2. CMH/DCH trained or experience.
□ 3. No training or experience, no significant concerns.
□ 4. Significant concerns (criminal history, driving record, does not agree with Corp. philosophy, etc.)

Reason:

_____

_____

_____

_____

_____

_____
Signature of interviewer

This form has been designed to strictly comply with State and Federal fair employment practice laws prohibiting employment discrimination.

IMPORTANT NOTE: A Criminal History does not necessarily preclude employment. However, providing false or misleading information during any part of the interview/application process WILL result in termination of employment.

R 400.1152 Offenses Evidencing Lack of Good Moral Character

Rule 2. (1)

(a) Conviction of the license applicant, in a court of competent jurisdiction, of any crime involving a substantial misrepresentation of any material fact, including any of the following:

(i) Bribery.
(ii) Fraud.
(iii) Filing of false claims.
(iv) Aiding or abetting the filing of false claims.
(v) Allowing an establishment to be used for illegal purposes.

(b) Conviction of the license applicant, in a court of competent jurisdiction, of any crime involving any of the following:

(i) Homicide.
(ii) Murder.
(iii) Manslaughter.
(iv) Mayhem.
(v) Negligent homicide.
(vi) Attempts to commit any of the offenses specified in paragraphs (i) and (ii) of this subdivision.

(c) Conviction of the license applicant, in a court of competent jurisdiction, of any crime, felony, or misdemeanor involving either of the following:

(i) Assault.
(ii) Battery.

(d) Conviction of the license applicant, in a court of competent jurisdiction, of any crime which involves a violent act, or a threat of a violent act, against a person or a crime constituting a sexual offense, which shall include any of the following:

(i) Criminal sexual conduct in any degree.
(ii) Activity for profit involving any of the following:
    (a) Child abuse, neglect, or exploitation.
    (b) Kidnapping.
    (c) Adoption schemes.
    (d) Prostitution or related crimes.
(iii) Cruelty toward, or torture of, any person.
(iv) Attempts to commit any of the offenses specified in paragraphs (i) and (iii) of this subdivision.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

MICHIGAN WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b require that a heath facility/agency that is a:

- Nursing Home
- Hospice
- Home for the Aged
- Adult Foster Care Facility (AFC)
- County Medical Care Facility
- Hospital that provides Swing Bed Services
- Home Health Agency
- Psychiatric Hospital/Inpatient Unit

Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC until the health facility/agency or AFC conducts a fingerprint-based criminal history check.

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health care facility/agency or AFC and has received a good faith offer of employment, an independent contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency or AFC to conduct a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment.

Note: Throughout this form:

- "Employee" includes persons independently contracted with and/or those granted clinical privileges.
- Clinical privileges do not apply to adult foster care facilities.

Health Facility or Agency

Licensee Name: _____ **Date:** _____

Employment Applicant Name: _____

Facility Name/License Number: _____

The health facility/agency or AFC:

a. May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a disqualifying crime or has been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. "Direct access" means regular access to a patient or resident, or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.
b. May terminate the background check or decide not to hire the individual at any stage of the process.
c. Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability for employment in a covered health care facility/agency or AFC.
d. Must retain verification of compliance with background check requirements.
e. Will make the final employment decision.

*This does not include a finding of abuse, neglect, or misappropriation (financial exploitation) substantiated under the Michigan Mental Health Code or Adult Protective Services Act.

Part 1 – Consent to Conduct Background and Criminal Record Checks

As a condition of being considered for employment:

a. I hereby consent to and authorize the health facility/agency or AFC to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a fingerprint-based search of state and federal criminal history records. I understand that this consent extends to the release and sharing of such information with the Michigan Departments of Licensing and Regulatory Affairs and State Police.

b. I hereby authorize the release of any relevant information to the health facility/agency or AFC to be used to conduct the background check as required under MCL 333.20173a, MCL 330.1134a, and MCL 400.734b.

c. I understand, except for a knowing or intentional release of false information, the health facility/agency or AFC has no liability in connection with a background check conducted under MCL 333.20173a, MCL 330.1134a, and MCL 400.734b or the release of criminal history record information for the purposes of making an employment decision.

d. I understand that the health facility/agency or AFC will make the final employment determination. I also understand that the health facility/agency or AFC may terminate the background check or decide not to hire me at any stage of the process.

e. I understand that the health facility/agency or AFC, in denying employment to an applicant, and reasonably relying on information obtained through a background check, is provided immunity from any action brought by an applicant due to the employment decision.

f. I agree to provide the information necessary to conduct a criminal background check.

g. Privacy Act Statement:

    a. Authority: Acquisition, preservation, and exchange of fingerprints and associated information by the Federal Bureau of Investigation (FBI) is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

    b. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

c. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine Uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

h. Procedure to Obtain a Change, Correction or Update of Identification Records:
If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections, or updating of the alleged deficiency; he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency. (28 CFR § 16.34)

i. Consent:
I understand that my personal information and biometric data being submitted by Live Scan, will be used to search against identification records from both the Michigan State Police (MSP) and the FBI for the purpose listed above. I hereby authorize the release of my personal information for such purposes and release of any records found to the authorized requesting agency listed above.

_____ _____

Signature of Applicant Date

Part 2 – This employment applicant information is required to process a complete and accurate criminal record check.

EMPLOYEE PERSONAL INFORMATION

First Name: _____

Middle Name: _____

Last Name: _____ Suffix: _____

OTHER NAME(S) USED (MAIDEN NAME, ALIAS)

First Name: _____

Middle Name: _____

Last Name: _____ Suffix: _____

(Please use back of form or attach additional sheets if needed to report all other/alias names used)

Date of Birth: _____ Social Security Number: _____

Country of Citizenship: _____

Place of Birth (City, State/Province): _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Gender: ☐ Female ☐ Male

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ White ☐ All

ADDRESS

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone Number: _____ Email Address: _____

Driver's License or State/Canadian ID Number: _____ _____

State/Prov. License/ID Number

RESIDENCY

Has this employment applicant resided in Michigan continuously for the past 12 months? ☐ YES ☐ NO

Job Title: _____ Conditional Hire Date: _____

PROFESSIONAL LICENSE(S)/CERTIFICATION(S)

1. License/Certification Number: _____
2. License/Certification Number: _____
3. License/Certification Number: _____

Part 3 – Employment Applicant Disclosure Statements

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, subsections (1)(a) through (g) describe crimes for which a conviction during the applicable time period will disqualify a person from being employed by, independently contracting with, or being granted clinical privileges in a covered health care facility/agency or AFC.

The above laws define "conviction" as, "… a final conviction, the payment of a fine, a plea of guilty or nolo contendere (no contest) if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime." For relevant crimes described under 42-USC 1320a-7(a), convicted means that term as defined in 42-USC 1320a-7. These definitions may include cases that resulted in an alternative sentencing agreement, including deferred or delayed sentences, and for relevant crimes under 42-USC 1320a-(7)(a), convictions which may have been expunged or set aside.

I hereby certify that:

a. I have not been convicted of 1 or more of the crimes described in subsection (1)(a) through (g) of MCL 333.20173a, MCL 330.1134a, or MCL 400.734b within the applicable time period described in each subdivision. Initial _____ Date _____

b. I have never been found Not Guilty by Reason of Insanity. Initial _____ Date _____

c. I have never been the subject of a substantiated finding of neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395i or 1396r.

Initial _____ Date _____

If you are not able to certify a, b, or c above, please explain below:

Offense/Finding	Date	City, State	Sentence	Discharge Date

I certify that the above statements are correct and complete to the best of my knowledge:

_____ _____

Signature of Applicant Date

Part 4 – Conditional Employment

If the health facility/agency or AFC determines it necessary to employ me pending the results of the state and federal criminal history background check, I understand the following:

a. If the background check reveals disqualifying information my employment will be terminated for good cause, unless and until I successfully prove that the disqualifying information is inaccurate, expunged, or set aside.
b. If I knowingly provided false information regarding my identity, criminal convictions, or substantiated findings of patient or resident neglect, abuse, or misappropriation of property, I may be guilty of a misdemeanor punishable by imprisonment for not more than 93 days and/or a fine of not more than $500.00.
c. I understand that as a condition of continued employment, I am required to report in writing to the health facility/agency or AFC immediately upon being arraigned on a felony charge or convicted of one of more of the criminal offenses as described in MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, or upon becoming the subject of an order or dispositional finding of "Not Guilty by Reason of Insanity," or upon being the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. Reporting of an arraignment is not cause for termination or denial of employment.

_____ _____

Signature of Applicant Date

Part 5 – Applicant Rights

a. I understand that upon my request, the health facility/agency or AFC can provide a copy of any disqualifying record information found on any of the relevant registries or databases.
b. I understand that if I believe the results of any disqualifying information found of any relevant registry is inaccurate, it is my responsibility to contact the agency that maintains the registry to correct the registry information.
c. I understand that if I believe the results of the criminal history fingerprint record are inaccurate, or if the conviction contained in the criminal history record is one that may be expunged or set aside, I may file an appeal with the Department of Licensing and Regulatory Affairs.

_____ _____

Signature of Applicant Date

Part 6- Disclaimer

The state of Michigan is not responsible for any additional information, requirements, or use of any substitute forms that the above-named health facility/agency or AFC provides to the applicant.

THIS FORM MUST BE MAINTAINED IN THE APPLICANT FILE AND SHALL BE MADE AVAILABLE TO THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS UPON REQUEST.

If you are concerned about maintaining personal information in the file, you may only black out the following information as all additional information is required by Michigan State Police:

Social Security Number **Telephone Number**
Address **Email Address**
Driver's License Number **Professional License/Certification Number(s)**

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY
(ORR CHECK)
Fax to 989-895-2715 or email to tmatuszewski@babha.org

I, _____ authorize Bay Arenac Behavioral Health (BABH) and the
(print full name)
BABH Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____ release BABH and BABH Office of Recipient Rights, its
(print full name)
officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____
3. _____ Dates employed: _____ to _____
4. _____ Dates employed: _____ to _____

_____	_____	_____
Applicant's Signature	**Date**	**Previous Names Used (print)**
_____	_____	_____
Witness Signature	**Date**	**Applicant's Birth Date**

INFORMATION TO BE SENT TO:

Central State Community Services
Provider/Consumer

2603 W. Wackerly St., Ste. 201
Street Address

Midland,	MI	48640	(989) 631-8760
City	**State**	**Zip Code**	**Fax**

RIGHTS OFFICE USE ONLY

The above applicant ☐ Does ☐ Does not have a substantiated recipient rights violation(s) according to BABH records.

By: _____ Date: _____
BABH Office of Recipient Rights

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, _____, authorize Genesee Health System (GHS) and the GHS
(print full name)
Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____, release GHS and the GHS Office of Recipient Rights, its officers, its agents
(print full name)
and its employees from any and all liability, claims, suits, and actions of any nature brought against GHS and the GHS Office of Recipient Rights, its officers, its agents and its employees etc. for disclosing the information requested by me and I shall indemnify and hold them harmless should any claims, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____

2. _____ Dates employed: _____ to _____

_____ _____ _____
Applicant's Signature **Date** **Other names used**

_____ _____
Witness Signature **Date**

INFORMATION TO BE SENT TO:

Central State Community Service
Provider/Consumer

2603 W Wackerly St Ste 201
Street Address

Midland MI 48640 989-631-8760
City **State** **Zip Code** **FAX**

Fax this form to: (810) 257-3790 for processing

RIGHTS OFFICE USE ONLY

An individual with the above name does have a substantiated recipient rights violation(s) according to GHS records.

By: _____ Date: _____
GHS Office of Recipient Rights

Revised: 3/22/13

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, _____, authorize Lapeer County Community Mental Health (LCCMH) and the
(print full name)
LCCMH Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, _____, release LCCMH and the LCCMH Office of Recipient Rights, its officers, its agents
(print full name)
and it's employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits, or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT:

1. _____ Dates employed: _____ to _____
2. _____ Dates employed: _____ to _____
3. _____ Dates employed: _____ to _____
4. _____ Dates employed: _____to _____
5. _____ Dates employed: _____to _____

_____ _____ _____
Applicant's Signature **Date** **Applicant's Maiden Name**

INFORMATION TO BE SENT TO:

Central State Community Services

_____
Provider
989-631-5760 kconner@cscsmi.com

_____
Fax # AND E-Mail Address

RIGHTS OFFICE USE ONLY

The above applicant does ☐ does not ☐ have a substantiated recipient rights violation(s) according to LCCMH records.

_____ _____
LCCMH Office of Recipient Rights Date

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

I, _____, authorize Oakland Community Health Network (OCHN) to disclose to
(PRINT FULL LEGAL NAME)
the PROVIDER listed below any and all information in your possession regarding any violations of recipients' rights committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal, State or common law.

I, _____, release Oakland Community Health Network, its officers, its agents
(PRINT FULL LEGAL NAME)
and its employees from any and all liability, claims, suits and actions of any nature brought against Oakland Community Health Network, its officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold them harmless should any such claims, suits or actions be filed against them.

_____ __/__/___
APPLICANT SIGNATURE DATE

_____
APPLICANT'S PREVIOUS NAME/S OR MAIDEN NAME (IF APPLICABLE)

_____ __/__/___
WITNESS SIGNATURE DATE
(Witness to ensure form is complete and legible before sending to process.)

_____
APPLICANT'S LAST 4 DIGITS OF SS#

INFORMATION TO BE SENT TO:
Central State Community Services
_____
PROVIDER
2603 W. Wackerly St. Suite 201
_____
ADDRESS
Midland, MI 48640
_____
CITY STATE ZIP CODE
(989) 631-6691 Kari Conner
_____
PHONE **CONTACT PERSON**

_____
APPLICANT'S DATE OF BIRTH
MONTH AND DAY ONLY

_____
DRIVER'S LICENSE #/STATE ID#

_____
DATE OF APPLICATION/HIRE

☐ Please fax this form back at 989-631-8760 Attn: H.R. Department
☐ Please mail this form back to the Provider address above, or email to this address_____

RIGHTS OFFICE USE ONLY

The above applicant does _____ does not _____ have substantiated recipient rights violation(s) according to Oakland Community Health Network records.

By: _____ DATE: _____
Vicki L. Suder, Director of Rights and Advocacy

ORR/Authorization to Disclose Revision 10-23-18

S-FAX (855) 828-4983

MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Office of Recipient Rights
19800 Hall Road
Clinton Township, MI 48038

Phone: 586-469-6528
Fax: 586-466-4131
info@mccmh.net
www.mccmh.net

AUTHORIZATION TO RELEASE RECIPIENT RIGHTS INFORMATION

I _____ hereby authorize Macomb County Community Mental Health Services, Office of Recipient Rights, to release to the following corporation/provider: Central State Community Services at the following address: 2603 W Wackerly St. Suite 201 Midland, MI and/or to the following **FAX NUMBER/OR EMAIL**: 989-631-8760, any written reports or records regarding substantiated violations of recipient rights against me.

I release the Macomb County Community Mental Health Services, Office of Recipient Rights (ORR), from any and all claims, liability and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Consumer and Industry Services and/or other community health agencies. I hereby consent to the release of information to these agencies.

_____
***Applicant's Name (please print clearly)

_____
Applicant's Signature Date
(Electronic Signature Verification Acceptable)

_____
Applicant's Maiden Name (please print clearly)

Last 4 digits of
Social Security Number: _____

_____ _____
Witness's Signature Date

Note: If an applicant disagrees with our findings, please contact This office prior to any dismissal to ensure we have the correct person and prevent a possible mix up in identities

ORR FAX: 586-466-4131
ORR EMAIL: orrclerical@mccmh.net

PLEASE PROVIDE COMPLETE MAILING ADDRESS AND/OR FAX NUMBER ON ALL RELEASE FORMS

*****If this form indicates the ***Applicant "DOES" have a substantiated Recipient Rights violation, please call the Office of Recipient Rights at: 586-469-6528 for details.**

FOR MCCMH ORR OFFICE USE ONLY

The individual named above ***DOES _____ DOES NOT _____ have a written report or record regarding a substantiated Recipient Rights violation of Abuse and/or Neglect against them.

_____ _____
Authorized Signature of the Office of Recipient Rights Date

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

Recipient Rights
Complaints
Appeals

PROVIDER INFORMATION:

Provider Name: Central State Community Services Inc.	*Phone:989 631-6691*	*Fax:989 631-8760*
Address:2603 W Wackerly Street Suite 201		
City: Midland	*State: MI*	*Zip Code:48640*

I, _____, authorize the Saginaw County Community Mental Health Authority
(PRINT FULL NAME)
to disclose to the PROVIDER listed above any and all information in your possession regarding any violations of recipients' rights committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal, State or common law.

Please check the appropriate box below

☐ I acknowledge that I have worked in the Mental Health field prior to my application for employment. I have worked in the following counties and give my permission for you to check with their county's Office of Recipient Rights: _____.

☐ I have not worked in the Mental Health field prior to my application for employment.

I, _____, release the Saginaw County Community Mental Health Authority
(PRINT FULL NAME)
and any other Community Mental Health Agencies I have listed on this form, its officers, agents, and employees from any and all liability, claims, suits and actions of any nature brought against them for disclosing the information requested by myself and the provider and I shall indemnify and hold them harmless should any such claims, suits or actions be filed against them.

_____ _____ _____
Applicant's Signature *Date* *Applicant's Maiden Name (If Applicable)*

_____ _____ _____
Witness Signature *Date* *Applicant's Social Security Number*

_____
Applicant's Home Address: *Street and Number* *City* *State* *Zip Code*

RIGHTS OFFICE USE ONLY

A) The above applicant ☐DOES ☐DOES NOT have substantiated recipient rights violation(s) of Abuse or Neglect according to Saginaw County Community Mental Health Authority.
B) The above applicant ☐DOES ☐DOES NOT have other substantiated Recipient Rights violation(s) against them according to Saginaw County Community Mental Health Authority.

By: _____ ***Date:*** _____
Recipient Rights Advisor or Officer

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION 5-06

RELEASE OF INFORMATION

RECIPIENT RIGHTS VIOLATION VERIFICATION

I, _____, agree to allow Sanilac County Community Mental Health Authority to release to:
Central State Community Services Fax #989-631-8760
(Name of Group Home Provider)

any information related to Recipient Rights investigations or complaints I have been involved with, for the purpose of verifying my eligibility for employment.

I have previously worked at the following homes in Sanilac County:

_____

_____

_____

I have previously worked under the following names:

_____

_____

Information obtained from Sanilac County Community Mental Health Authority will not be further released without my written consent. I release Central State Community Services (Name of Provider), Sanilac County Community Mental Health Authority, the Office of Recipient Rights, and their employees from all liability or claims.

Signed: _____ Date: _____

Office of Recipient Rights Response:

☐ No known rights violations since 1997 according to Office of Recipient Rights records of Sanilac County CMH.

☐ The following violations and dates were noted in the Office of Recipient Rights records of Sanilac County CMH:

_____

_____

_____

Signed: _____ Date: _____
Recipient Rights Officer

Sanilac CMH Recipient Rights Office Fax #: (810) 648-0379

CENTRAL STATE COMMUNITY SERVICES, INC.

CNA – REGISTER
(NAR, ORR, AND CSCS DATABASE)

On, _____, the CNA Register (NAR) was checked for information regarding by

_____ for information regarding, _____, SS# _____.
(HR Initials) **(Candidate's name- printed)**

_____ No history of abuse or neglect has been reported.

_____ Yes, a history was found.

On, _____, The Office(s) of Recipient Rights was contacted (_____email -_____fax)

by _____, for information regarding _____, SS# _____.
(HR Initials) **Candidate's name-printed)**

For the following counties:

Genesee: _____/ _____ Macomb: _____/ _____

Bay: _____/ _____ Sanilac: _____/ _____

Saginaw: _____/_____ Midland: _____/_____ (email)

Huron: _____/ _____ Lapeer: _____ / _____(email)

Oakland: _____/_____

On, _____, _____ the Midland Administrative Office received response via email/fax
(HR Initials)

(Per GHS policy, if no response received within 48 business hrs. no history was found.)

_____ No history of abuse or neglect has been reported.

_____ Yes, a history was found. Please report to Program Manager

_____ Agency refuses to disclose information. *(CEI use only)*

On, _____, Central State Community Services, Inc., Employee Database (HRMS) was

checked by _____for information regarding _____, SS# _____.
(HR Initials) **(Candidate's name-printed)**

_____ No history of employment was found.

_____ Yes, a history was found. * **Please proceed with the Rehire Approval Form**

Dates of employment: _____

Reason for separation: _____

Rehire Approval Form completed and sent: _____ (Date/Initials)