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.)

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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
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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

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
( ) -		

☐ 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.)
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