

## Family Care Safety Registry Screening

Full Name: \_\_\_\_\_  
First Middle Last

Maiden/Alias Names: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State Zip Code

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
Month Day Year

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Go to: [www.dhss.mo.gov/fcsr](http://www.dhss.mo.gov/fcsr)

Is applicant registered? Yes/No If no, information was entered: \_\_\_\_\_  
Date

If yes, screening was completed by phone on: \_\_\_\_\_ (1-866-422-6872)  
Date

Based on the Name, SS# and Date of Birth given above, no finding was reported in the FCSR background screening and the written FCSR

form should be received by: \_\_\_\_\_  
Date

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Signature of Preparer

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Date