CDS Attendant Application Packet

Date: _____

Employer (Participant) Name (print): _____

Employee (Attendant) Name (print): _____

Has the participant you are applying to work for already been accepted on CDS Services with Life Unlimited?

- ☐ No
- ☐ Yes

Are you related to the participant you are applying to work for?

- ☐ No
- ☐ Yes

If yes, how are you related?

- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Grandchild
- ☐ Cousin
- ☐ Other _____

Please note, you are not eligible to work as an attendant for your spouse or someone you are a legal guardian of.

Have you lived in Missouri for the last five (5) years? ☐ No ☐ Yes

If not, what other states have you lived in?_____

Are you at least 18 years old? ☐ No ☐ Yes

If not, when will you turn 18? _____

For Office Use Only

Date Received:

Staff Initials:

Date Scanned:

Current Attendant? ☐Yes ☐ No

Direct Deposit Received
☐Yes ☐ No ☐ Pay Card Requested

Consumer Directed Services
Attendant Application

Personal Data

Name: _____

Address: _____
Street address City State Zip

Phone: (home) _____ (cell) _____ (message phone) _____

What is your primary mode of transportation?
☐ Personal Vehicle ☐ Public Transportation (i.e. bus) ☐ Other: _____

Some participants may have allergies, do you smoke? ☐ Yes ☐ No

Do you have any criminal convictions, findings of guilt, pleas of guilty and or pleas of nolo contendere except minor traffic offenses? ☐ Yes ☐ No
If yes, describe offense and when it occurred:

_____

_____

Experience & Qualifications

Have you ever been an attendant for the CDS Program? ☐ Yes ☐ No

How did you learn about this position? _____

Have you ever worked with persons with disabilities? ☐ Yes ☐ No

Are you a Certified Nursing Assistant (CNA)? ☐Yes ☐ No

Please check boxes you have experience in:

Personal Care
☐ Bathing
☐ Dressing/grooming
☐ Toileting
☐ Mobility/transfer
☐ Hoyer lift
☐ Assist with ambulation

Other plan of care tasks
☐ General housekeeping
☐ Laundry
☐ Meal Preparation or assistance with eating
☐ Meal clean-up
☐ Shopping for someone
☐ Transporting participant for errands (groceries, bills, etc.)

What relevant experience do you have that is not mentioned above?

_____

_____

Employment History (most recent first)

Company Name: _____ Phone: _____
Address: _____
Dates of employment: (from) _____ (to) _____
Position: _____ Duties: _____
Reason for leaving: _____
Are you eligible for re-hire? ☐ Yes ☐ No
If no, explain why: _____

Company Name: _____ Phone: _____
Address: _____
Dates of employment: (from) _____ (to) _____
Position: _____ Duties: _____
Reason for leaving: _____
Are you eligible for re-hire? ☐ Yes ☐ No
If no, explain why: _____

Do you wish for your previous employers to be contacted? ☐ Yes ☐ No

References

Please list three personal references not related to you.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

- *I certify that the answers given herein are true and complete to the best of my knowledge.*
- *I understand that if I transport a participant in my car, I take on the assumption of liability.*
- *By signing this application, I give consent to a pre-employment criminal record check and a closed record check pursuant to section 610.210.RSMo.*

_____ _____
Applicant signature Date

Life Unlimited accepts job applications for attendant positions as a service to participants who may need an attendant. Life Unlimited is not the employer or independent contractor for or with participants or attendants. Attendants are responsible for negotiating working relationships with individual participants, including discussion of responsibility for payment of taxes, etc.

Last Revision Date: 6/22/2026

Personal Care Attendant Background Checks

I, the undersigned, understand in order to work as a personal care attendant for a participant of the CDS Program must register with the Family Care Safety Registry as described in Missouri Statute 210.900RSMo.

I understand background checks, which include any discrepancies, could be cause for me to file a "Good Cause Waiver" and forward the positive results to Life Unlimited, before employment as a personal care attendant can begin.

☐ *I currently have NO discrepancies on my background including listings with the Missouri Highway Patrol, Missouri Department of Social Services, Missouri Department of Health and Senior Services, Missouri Department of Mental Health.*

☐ *I currently HAVE one or more discrepancies on my background.*

☐ *I have received and completed a Good Cause Waiver Application.*
☐ *I have NOT received and completed a Good Cause Waiver Application.*

_____

Applicant Name (print)

_____

Applicant Signature

Date: _____

Last Revision Date: 2/2/2026

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

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.** Register only once!

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
- ☐ Missouri Foster Parent/Family Member of Foster Parent
  Children's Division 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 **$15.00** applies to all categories except Missouri Foster Parents, who must list the Missouri Children's Division county office.

Have you or an immediate family member ever served in the U.S. Armed Forces? ☐ Yes ☐ No

If Yes, would you like information about military-related services in Missouri? ☐ Yes ☐ No

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)

BIRTH NAME (LIST FULL NAME)	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 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	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 Elementary and Secondary Education
- 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).

CDS Payroll - Attendant Direct Deposit Form

MANDATORY - PLEASE COMPLETE FOR DIRECT DEPOSIT

Banking Information

I would like my wages/salary deposited to the bank account attached.
Unfortunately, we are UNABLE to accept direct deposit tickets or handwritten account information.

☐ NEW / ADD
Bank Name: _____ ☐ Checking ☐ Savings

☐ CANCEL
Bank Name: _____ ☐ Checking ☐ Savings

IMPORTANT NOTICE: We CANNOT deposit into an account that is in the participant/employer's name. This includes shared accounts.

☐ I do not have a bank account and request to receive my payroll through a pay card.

Employee Information (please print)

Employee Name:_____

Social Security Number:_____

Employer (Participant) Name:_____

I hereby authorize my **employer**, (listed above and hereinafter **COMPANY**), to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter **BANK**) indicated above. Further, I authorize **BANK** to accept and to credit any credit entries indicated by **COMPANY** to my account. In the event that **COMPANY** deposits funds erroneously into my account, I authorize **COMPANY** to debit my account for an amount not to exceed the original amount of the erroneous credit. For my convenience, I request that Life Unlimited directly deposit my wages/salary earned from my employer into my bank account. I understand that deposit of my earnings into my account by Life Unlimited may be an advance of funds on behalf of my employer, which is subject to the successful collection of these funds by Life Unlimited from my employer's bank. If, within 30 days of Life Unlimited making the deposit into my account, my employer does not make available to Life Unlimited the funds that were advanced to make the deposit into my account, I authorize Life Unlimited to charge my account to recover said advance. I agree to hold Life Unlimited harmless from loss and to indemnify it, limited to the amount of deposit. This authorization is to remain in full force and effect until **COMPANY** and **BANK** have received written notice from me of its termination in such time and in such manner as to afford **COMPANY** and **BANK** a reasonable opportunity to act on it.

Employee Signature _____ Date_____

PLEASE ATTACH VOIDED CHECK OR DOCUMENTATION FROM YOUR BANK

Attach only a void check or documentation that includes the following: bank name, name of account holder, type of account, account number, and bank routing number.

Unfortunately, we are UNABLE to accept direct deposit tickets or handwritten account information.

PLEASE DO NOT STAPLE

Last Revision Date: 6/8/2026