

# Identix

## Missouri Registration

Items marked with a \* are required

First Name\*

Last Name\*

Alias

Street Address\*

City \*

State\*

Home Phone\*

Work Phone

Email Address

Date of Birth (09/26/1972)\*

Gender\*

Ethnicity\*

Hair Color\*

Citizen Country\*

Immigration Status\*

Drivers License or State ID Number

**TO BE FILLED OUT BY EMPLOYER:**

Payment Method \*

## Personal Info

Middle Name

Suffix

Apt. Number

Zip Code\*

Country\*

Extension

Cell Phone

Height\*

 ft.  in.

Weight\*

Eye Color\*

Place of Birth\*

Immigration Date (09/26/1972)

Alien Registration Number

Issuing State of Drivers License or State ID

Billing Account Number \*

# CONFIDENTIAL

MISSOURI DEPARTMENT OF MENTAL HEALTH

## AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the Missouri Highway Patrol, Federal Bureau of Investigation, and the Missouri Department of Social Services to release to the Missouri Department of Mental Health any criminal record on file concerning me. This information will be made a part of my office personnel record. However, the facility personnel office shall use it only for those purposes which relate to present and future employment consideration by the Department of Mental Health.

### *Please Print*

DATE \_\_\_\_\_ NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_

Please complete the following

Please check one:

DATE OF BIRTH \_\_\_\_\_

\_\_\_\_\_ MALE

HEIGHT \_\_\_\_\_

\_\_\_\_\_ FEMALE

WEIGHT \_\_\_\_\_

EYE COLOR \_\_\_\_\_

HAIR COLOR \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_

ALIASES \_\_\_\_\_

CITIZENSHIP \_\_\_\_\_

Please check one:

\_\_\_\_\_ WHITE OR HISPANIC

\_\_\_\_\_ ASIAN OR PACIFIC ISLANDER, VIETNAMESE

\_\_\_\_\_ BLACK

\_\_\_\_\_ INDIAN, AMERICAN OR ALASKAN NATIVE

\_\_\_\_\_ UNKNOWN

SIGNATURE \_\_\_\_\_



**MISSOURI DEPARTMENT OF SOCIAL SERVICES  
APPLICATION FOR RECORD REVIEW**

Dept of Mental Health  
Central Office – Attn: Brenda Thompson (HR)  
1706 East Elm  
Jefferson City, MO 65101

Mail To:

| <b>IDENTIFYING DATA (PLEASE PRINT)</b>   |      |   |   |
|--|------|---|---|
| 1. EMPLOYEE NAME (LAST) (FIRST) (MIDDLE) (JR., SR., III)   |      |   | 2. DATE OF BIRTH                              |
| 3. GENDER (CHECK ONE):<br><input type="checkbox"/> M-MALE <input type="checkbox"/> F-FEMALE  |      | 4. RACE (CHECK ONE):<br><input type="checkbox"/> W - WHITE <input type="checkbox"/> B-BLACK <input type="checkbox"/> H - HISPANIC <input type="checkbox"/> N - NATIVE AMERICAN <input type="checkbox"/> A- ASIAN/PACIFIC ISLANDER |   |
| 5. SOCIAL SECURITY NUMBER  |      | 6. DRIVER'S LICENSE NUMBER<br><input type="checkbox"/> NONE   | 7. STATE                                      |
| <b>BACKGROUND INFORMATION</b>  |      |   |   |
| 1. MAIDEN NAME   |      | 2. ALL NICKNAMES  |   |
| 3. ALL ALIASES   |      | 4. ALL OTHER NAMES FORMERLY USED  |   |
| 5. PLACE OF BIRTH (CITY AND STATE)   |      | 6. PRESENT ADDRESS (STREET) (CITY) (COUNTY) (STATE) (ZIP CODE)  |   |
| 7. TELEPHONE NUMBERS WHERE APPLICANT CAN BE CONTACTED (GIVE HOME NUMBER FIRST)   |      | 8. ALL PLACES OF RESIDENCE OTHER THAN MISSOURI FOR PAST 10 YRS (CITY & STATE) (ATTACH SEPARATE PAGE, IF NECESSARY)  |   |
| 9. ALL PREVIOUS RESIDENTIAL ADDRESSES FOR THE PAST 5 YEARS (ATTACH A SEPARATE PAGE, IF NECESSARY) (STREET) (CITY) (STATE) (ZIP)  |      | (STREET) (CITY) (STATE) (ZIP)   |   |
| (STREET) (CITY) (STATE) (ZIP)  |      | (STREET) (CITY) (STATE) (ZIP)   |   |
| 10. For any criminal acts other than minor traffic offenses (DWI is not considered a minor traffic offense), have you been convicted, pled guilty or nolo contendere, or received a suspended imposition of sentence in any state of the United States regardless of whether incarceration actually occurred?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete the next two lines.   |      |   |   |
| DATE (CITY) (STATE) (COUNTY)   |      | DATE (CITY) (STATE) (COUNTY)  |   |
| CIRCUMSTANCES (IDENTIFY CHARGES) USE REVERSE SIDE OF THIS FORM OR ATTACH A SEPARATE PAGE, IF NECESSARY   |      |   |   |
| 11. Have you ever been involved as a perpetrator in any child abuse or elderly abuse which resulted in the physical, mental, or emotional abuse or neglect, or sexual abuse of a child, elderly person or eligible adult which was substantiated and documented by a state agency but not necessarily proven in court and whether a criminal conviction of any kind also occurred?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete the next two lines.  |      |   |   |
| DATE (CITY) (STATE) (COUNTY)   |      | DATE (CITY) (STATE) (COUNTY)  |   |
| CIRCUMSTANCES (ATTACH A SEPARATE PAGE, IF NECESSARY)   |      |   |   |
| 12. Have you or any member of your household received public assistance benefits to which you or your household were not entitled?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>If yes, have all such benefits been repaid in full to the State of Missouri?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |      |   |   |
| I hereby swear or affirm under penalty of perjury that I am the Applicant for a Record Review and that the information provided in this application is true and accurate. Via my signature, I hereby grant the Department of Social Services my unqualified permission to make inquiry into any and all information relevant to this "Application for Record Review." I further waive all rights to confidentiality regarding such information and forever release the Department of Social Services and its agents and employees from all liability regarding the use of the information. |      |   |   |
| By my signature, I also affirm and recognize that in the event I have furnished false information or have failed to furnish required information for a record review on this application or for any employment history given to my employer, I will be in violation of DSS Background Checks for DSS Employees Policy (2-107) and may be subject to disciplinary action up to and including dismissal.   |      |   |   |
| I hereby authorized the Department of Social Services to investigate, obtain and compile information concerning my employment history, to obtain a copy of my college transcript(s), and to conduct an annual record review of myself, including information pertaining to any report of child or adult abuse or neglect revealed by an examination of government abuse/neglect records and/or information related to any convictions for criminal acts.   |      |   |   |
| SIGNATURE  | DATE | EMPLOYING DIVISION<br><b>DMH / CRTC – 650</b>   | WORK LOCATION/COUNTY<br><b>CAPE GIRARDEAU</b> |
| <b>TO BE COMPLETED BY PERSONNEL OFFICER</b>  |      |   |   |
| EMPLOYING DIVISION<br><b>DMH/ CRT - 650</b>  |      | WORK LOCATION/COUNTY<br><b>COTTONWOOD / CAPE GIRARDEAU</b>  | JOB CLASSIFICATION                            |



MISSOURI DEPARTMENT OF REVENUE  
DIVISION OF TAXATION AND COLLECTION  
**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**  
(Compliance with Section 105.262, RSMo)

I, \_\_\_\_\_, authorize and request the Missouri Department of Revenue to release confidential individual income tax information to

Cottonwood Residential Treatment Center (name of agency or department).

I understand the release of this information is to ensure I am in compliance with the individual income tax filing and paying requirements as described in Section 105.262, RSMo. I further agree that this authorization will be effective immediately upon my signature. If I am employed by the State of Missouri, this authorization will be ongoing until I leave employment from the State of Missouri.

My social security number is: \_\_\_\_\_

The Director of Revenue and Department personnel, are hereby released from any and all liability pursuant to unauthorized disclosures of confidential tax information resulting from release of information under Section 32.057, RSMo, or any other applicable confidentiality statute.

*Under penalties of perjury, I declare that I have examined this form and to the best of my knowledge and belief it is true, correct, and complete.*

SIGNATURE:

DATE

**This form is to be retained by the Agency. Do not send to the Department of Revenue.**

## SELECTIVE SERVICE REGISTRATION

The U.S. Military Selective Service Act, 50 U.S.C. App.451, et seq, requires males aged 18 through 26 to register with the Selective Service Administration. In support of this federal regulation, the State of Missouri requires that individuals employed by the State be registered with the Selective Service Administration.

If you are a male, 18-26 years of age, please complete the following certification by checking the appropriate item and signing in the space provided.

-----

\_\_\_\_\_ I certify that I am registered with the Selective Service Administration.

\_\_\_\_\_ I certify that I am not required to register with the Selective Service Administration under applicable provisions of the Military Services Act and its implementing regulations.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*

*(If you have not already not so, you may register with the Selective Service Administration on-line at [www.sss.gov](http://www.sss.gov))*

**JEREMIAH W. (JAY) NIXON**  
GOVERNOR

**KEITH SCHAFER, Ed.D.**  
DIRECTOR

**MARK STRINGER**  
DIRECTOR  
DIVISION OF ALCOHOL  
AND DRUG ABUSE  
(573) 751-4942  
(573) 751-7814 FAX

and  
ACTING DIRECTOR  
DIVISION OF COMPREHENSIVE  
PSYCHIATRIC SERVICES  
(573) 751-8017  
(573) 751-7815 FAX



**JULIE INMAN**  
SOUTHEAST REGION EXECUTIVE OFFICER

**MARTHA A. CASSEL**  
CHIEF OPERATING OFFICER

STATE OF MISSOURI  
**DEPARTMENT OF MENTAL HEALTH**  
DIVISIONS OF ALCOHOL AND DRUG ABUSE  
AND  
COMPREHENSIVE PSYCHIATRIC SERVICES

COTTONWOOD RESIDENTIAL TREATMENT CENTER  
1025 NORTH SPRIGG STREET  
CAPE GIRARDEAU, MO 63701  
PH.: 573-290-5888  
FAX: 573-290-5895  
[www.dmh.mo.gov](http://www.dmh.mo.gov)

**COMPANY** \_\_\_\_\_ **SUPERVISOR** \_\_\_\_\_  
(Please do not use a relative)

**STREET ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

The person identified below is being considered for employment and has signed the statement below authorizing reference check. Please complete the reverse side of this letter and return to us by one of the following methods:

- **By fax: 573-290-5124**

Sincerely,

Kim Pobst  
Human Resources Director

I hereby authorize the above employer or former employers to use employment records and/or personal knowledge to provide the information requested on the reverse side of this letter. I release this employer from any and all liability pertaining to the disclosure and content of this information.

Name: \_\_\_\_\_ Previous Name(s): \_\_\_\_\_

Position Held: \_\_\_\_\_ SSN: \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to: \_\_\_\_\_ Eligible for Rehire? \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason for Leaving: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMPLOYER REFERENCE

**Note:** This applicant has authorized you to provide the following information and releases you from any and all liability in providing this information. Due to the nature of the work with the Missouri Department of Mental Health, it is extremely important that complete and accurate information be provided. Please respond to all questions when possible. If you have no knowledge of this person, or if information is not available, please specify. An incomplete reference may have a negative effect on this applicant's employment eligibility with the Missouri Department of Mental Health.

|  |     |    |
|--|-----|----|
| Is the information provided by the applicant correct? If no, provide correct information under comments. | YES | NO |
|--|-----|----|

|   |     |    |     |
|---|-----|----|-----|
| Did the applicant leave in good standing? | YES | NO | N/A |
|---|-----|----|-----|

|   |     |    |     |
|---|-----|----|-----|
| Is the applicant eligible for re-employment with your agency? If no, please provide details under comments. | YES | NO | N/A |
|---|-----|----|-----|

|               | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | NO KNOWLEDGE |
|---------------|---------------|---------|---------------|--------------|
| Work Quality  |               |         |               |              |
| Work Attitude |               |         |               |              |
| Attendance    |               |         |               |              |
| Punctuality   |               |         |               |              |
| Honesty       |               |         |               |              |
| Initiative    |               |         |               |              |

**COMMENTS:**

---



---



---

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Printed Name

\_\_\_\_\_ **Title:** \_\_\_\_\_  
Signature

If necessary, may we contact you by phone? Yes \_\_\_\_\_ No \_\_\_\_\_ Phone # \_\_\_\_\_

**JEREMIAH W. (JAY) NIXON**  
GOVERNOR

**KEITH SCHAFER, Ed.D.**  
DIRECTOR

**MARK STRINGER**  
DIRECTOR  
DIVISION OF ALCOHOL  
AND DRUG ABUSE  
(573) 751-4942  
(573) 751-7814 FAX

and  
ACTING DIRECTOR  
DIVISION OF COMPREHENSIVE  
PSYCHIATRIC SERVICES  
(573) 751-8017  
(573) 751-7815 FAX



**JULIE INMAN**  
SOUTHEAST REGION EXECUTIVE OFFICER

**MARTHA A. CASSEL**  
CHIEF OPERATING OFFICER

STATE OF MISSOURI  
**DEPARTMENT OF MENTAL HEALTH**  
DIVISIONS OF ALCOHOL AND DRUG ABUSE  
AND  
COMPREHENSIVE PSYCHIATRIC SERVICES

COTTONWOOD RESIDENTIAL TREATMENT CENTER  
1025 NORTH SPRIGG STREET  
CAPE GIRARDEAU, MO 63701  
PH.: 573-290-5888  
FAX: 573-290-5895  
[www.dmh.mo.gov](http://www.dmh.mo.gov)

**COMPANY** \_\_\_\_\_ **SUPERVISOR** \_\_\_\_\_  
(Please do not use a relative)

**STREET ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_

The person identified below is being considered for employment and has signed the statement below authorizing reference check. Please complete the reverse side of this letter and return to us by one of the following methods:

- **By fax: 573-290-5124**

Sincerely,

Kim Pobst  
Human Resources Director

I hereby authorize the above employer or former employers to use employment records and/or personal knowledge to provide the information requested on the reverse side of this letter. I release this employer from any and all liability pertaining to the disclosure and content of this information.

Name: \_\_\_\_\_ Previous Name(s): \_\_\_\_\_

Position Held: \_\_\_\_\_ SSN: \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to: \_\_\_\_\_ Eligible for Rehire? \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason for Leaving: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMPLOYER REFERENCE

**Note:** This applicant has authorized you to provide the following information and releases you from any and all liability in providing this information. Due to the nature of the work with the Missouri Department of Mental Health, it is extremely important that complete and accurate information be provided. Please respond to all questions when possible. If you have no knowledge of this person, or if information is not available, please specify. An incomplete reference may have a negative effect on this applicant's employment eligibility with the Missouri Department of Mental Health.

|  |     |    |
|--|-----|----|
| Is the information provided by the applicant correct? If no, provide correct information under comments. | YES | NO |
|--|-----|----|

|   |     |    |     |
|---|-----|----|-----|
| Did the applicant leave in good standing? | YES | NO | N/A |
|---|-----|----|-----|

|   |     |    |     |
|---|-----|----|-----|
| Is the applicant eligible for re-employment with your agency? If no, please provide details under comments. | YES | NO | N/A |
|---|-----|----|-----|

|               | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | NO KNOWLEDGE |
|---------------|---------------|---------|---------------|--------------|
| Work Quality  |               |         |               |              |
| Work Attitude |               |         |               |              |
| Attendance    |               |         |               |              |
| Punctuality   |               |         |               |              |
| Honesty       |               |         |               |              |
| Initiative    |               |         |               |              |

**COMMENTS:**

---



---



---

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Printed Name

\_\_\_\_\_ **Title:** \_\_\_\_\_  
Signature

If necessary, may we contact you by phone? Yes \_\_\_\_\_ No \_\_\_\_\_ Phone # \_\_\_\_\_

JEREMIAH W. (JAY) NIXON  
GOVERNOR

KEITH SCHAFER, Ed.D.  
DIRECTOR

MARK STRINGER  
DIRECTOR  
DIVISION OF ALCOHOL  
AND DRUG ABUSE  
(573) 751-4942  
(573) 751-7814 FAX

and  
ACTING DIRECTOR  
DIVISION OF COMPREHENSIVE  
PSYCHIATRIC SERVICES  
(573) 751-8017  
(573) 751-7815 FAX



JULIE INMAN  
SOUTHEAST REGION EXECUTIVE OFFICER

MARTHA A. CASSEL  
CHIEF OPERATING OFFICER

STATE OF MISSOURI  
DEPARTMENT OF MENTAL HEALTH  
DIVISIONS OF ALCOHOL AND DRUG ABUSE  
AND  
COMPREHENSIVE PSYCHIATRIC SERVICES

COTTONWOOD RESIDENTIAL TREATMENT CENTER  
1025 NORTH SPRIGG STREET  
CAPE GIRARDEAU, MO 63701  
PH.: 573-290-5888  
FAX: 573-290-5895  
[www.dmh.mo.gov](http://www.dmh.mo.gov)

COMPANY \_\_\_\_\_ SUPERVISOR \_\_\_\_\_  
(Please do not use a relative)

STREET ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

The person identified below is being considered for employment and has signed the statement below authorizing reference check. Please complete the reverse side of this letter and return to us by one of the following methods:

- By fax: 573-290-5124

Sincerely,

Kim Pobst  
Human Resources Director

I hereby authorize the above employer or former employers to use employment records and/or personal knowledge to provide the information requested on the reverse side of this letter. I release this employer from any and all liability pertaining to the disclosure and content of this information.

Name: \_\_\_\_\_ Previous Name(s): \_\_\_\_\_

Position Held: \_\_\_\_\_ SSN: \_\_\_\_\_

Employment Dates: \_\_\_\_\_ to: \_\_\_\_\_ Eligible for Rehire? \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason for Leaving: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMPLOYER REFERENCE

**Note:** This applicant has authorized you to provide the following information and releases you from any and all liability in providing this information. Due to the nature of the work with the Missouri Department of Mental Health, it is extremely important that complete and accurate information be provided. Please respond to all questions when possible. If you have no knowledge of this person, or if information is not available, please specify. An incomplete reference may have a negative effect on this applicant's employment eligibility with the Missouri Department of Mental Health.

|  |     |    |
|--|-----|----|
| Is the information provided by the applicant correct? If no, provide correct information under comments. | YES | NO |
|--|-----|----|

|   |     |    |     |
|---|-----|----|-----|
| Did the applicant leave in good standing? | YES | NO | N/A |
|---|-----|----|-----|

|   |     |    |     |
|---|-----|----|-----|
| Is the applicant eligible for re-employment with your agency? If no, please provide details under comments. | YES | NO | N/A |
|---|-----|----|-----|

|               | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | NO KNOWLEDGE |
|---------------|---------------|---------|---------------|--------------|
| Work Quality  |               |         |               |              |
| Work Attitude |               |         |               |              |
| Attendance    |               |         |               |              |
| Punctuality   |               |         |               |              |
| Honesty       |               |         |               |              |
| Initiative    |               |         |               |              |

**COMMENTS:**

---



---



---

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Printed Name

\_\_\_\_\_ **Title:** \_\_\_\_\_  
Signature

If necessary, may we contact you by phone? Yes \_\_\_\_\_ No \_\_\_\_\_ Phone # \_\_\_\_\_