

**RESIDENTIAL SUPPORT SERVICES, INC
EMPLOYEE AGREEMENT**

Name: _____

Date: _____

Prior to any employment offer with Residential Support Services, per our policy we require the following background checks to be completed on every employee.

- ***Criminal Background Check***
- ***Child Protective Background Check***
- ***Medicaid Fraud***
- ***Social Security Number Verification***
- ***Driving Record Background***
- ***Drug Testing/Pre Employment***
- ***References-Up to Three***
- ***Work References-Last Two Jobs***

If your drug test comes back negative/dilute you will be required to retest and at your own expense. This is Residential Support Services policy. Failure to complete any of the above satisfactorily, will result in Residential Support Services withdrawing or denying a job offer.

Signed:_____

Date:_____

Witnessed:_____

Witnessed Date:_____

******AS OF AUGUST 3RD 2012, IT IS MANDATORY THAT ALL APPLICANTS BE LICENSED TO DRIVE AND INSURABLE (ACCORDING TO RSS INSURABILITY) WITHIN 90 DAYS OF BEING OFFERED EMPLOYMENT WITH RSS. FAILURE TO BECOME LICENSED IN THE REQUIRED TIME FRAME WILL RESULT IN THE TERMINATION OF YOUR POSITION.******

APPLICANT SIGNATURE: _____



2110 Overland Ave # 128
Billings, Montana 59102

TELEPHONE (406) 248-4211
FAX (406) 248-4554

REFERENCE RELEASE AUTHORIZATION

To be Signed by Applicant

I authorize Residential Support Services, employers and references to disclose any and all relevant information concerning any prior employment records and pertinent information.

I hereby release all parties and persons connected with furnishing such information from all claims, liabilities and damages for whatever reason, arising out of providing such information.

Applicant's Signature

Date

To be completed by individual providing the reference.
Please complete front and back of the form.
Thank you for your assistance.

Date: _____

Re: _____

Dear: _____

The above named individual has listed your name as an employer or personal reference. The individual has signed a release to disclose information to Residential Support Services. Please complete this form and return it to our office at your earliest convenience. Your assistance is greatly appreciated.

Length of time that you have known applicant: _____

Circumstances of your acquaintance with this person: _____



Release of Driving Records

(Montana Driver Privacy Protection Act)

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-3816

Office Use

1. Requested Information

[3] **A.** Your Driving Record – Complete Sections 3, 4, 5, and 6.

[3] **B.** Another Person's Driving Record – Complete all sections, including Intended Use below.

Intended Use: To be completed if you checked B above.

[1] For use by a federal, state, or local government agency, including a law enforcement agency or any individual acting on behalf of the agency in carrying out its functions.

[2] For use by a business or its agents, employees, or contractors in their normal course of business to verify the accuracy of personal information submitted by the individual to the business or its agents, employees, or contractors. If the submitted information is not correct or no longer correct, to obtain the correct information for the purposes of preventing fraud by pursuing legal remedies against or recovering on a debt or security interest against the individual.

[4] With written consent of the individual(s) who is the subject(s) of this search - A signed and dated Personal Information Express Consent form must be attached.

[5] For use as part of a civil, criminal, administrative, or arbitrative proceeding in any court or government agency or before any self-regulatory body, including the service of process, an investigation in anticipation of litigation, and the execution or enforcement of judgments and orders, pursuant to an order of any court.

[6] For use by an insurer, insurance support agency, or self-insured entity in connection with the investigation of claims, antifraud activities, ratemaking, or underwriting.

[7] For use by a licensed private investigator or security service for any purpose authorized under Montana law.

[8] For use by an employer or its agent to verify information related to a holder of a commercial driver license required under federal or Montana law.

[9] For use in providing notice to the owners of towed, abandoned, or impounded vehicles.

[10] For use by a parent of a child under 18 years of age.

[11] For any other use that is specifically related to the operation of a motor vehicle or to public safety and is authorized under Montana law.

2. Requestor Information

Name of Requestor: _____

Employer/Company: (if applicable) _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Residential Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Driver License #: _____

3. Search Information: This section must be complete.

Full Name: _____

Date of Birth: _____

Driver License #: _____

4. Driving Records Fees

Make checks payable to: Motor Vehicle Division

Driving Record = \$4 per record

Certified Driving Record = \$10 per record * Cannot Be Faxed *

Faxing of Record = Additional \$3 per record
Fax #: _____

Mailing of Record = Additional \$3 per mailing (unless self-addressed, stamped envelope is included)

Total = \$ _____

5. Certification (Signature must be notarized unless a copy of requestor's driver license or state-issued identification card is enclosed.)

I have read the Montana Driver Privacy Protection Act, MCA 61-11-501 through 61-11-516, and understand the limitations placed on the use of information received from the Montana Department of Justice, Motor Vehicle Division, Records and Driver Control Bureau. Under penalty of law (MCA 45-7-203), I certify that the statements made and information contained on this form are true and correct to the best of my knowledge, information, and belief; I am the person named on this form; and, if signing for a business entity or trust, I have full authority to do so.

Signature of requestor: _____

Printed Name: _____ Date: _____

Section 6 notarization must be completed – OR – you must attach a legible copy of your state or government-issued photo ID, including driver license, identification card, or passport, none of which can be expired for more than four years.

6. Notarization (unless ID is provided)

State of _____	County of _____	Signed before me on (date) _____	Notary Stamp/Seal
By (clearly print name of person signing form) _____			
Notary signature _____			



Personal Information Express Consent Form

P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-3816

This form is to be used to authorize the Department of Justice, Motor Vehicle Division, to release certain records to another person or entity. Complete this form if you have checked the first box of the **Intended Use** portion of Section 1 on the Release of Driving Records form (34-0100).

Name: _____
Print Full Name

Driver License #: _____ Date of Birth: _____

Residing at: _____
Street City State Zip Code

I hereby authorize the Department of Justice to release my:
 Driving Record Vehicle Record

To the following individual and/or company:

Name: _____
Print Full Name

Address: _____
Street City State Zip Code

Under penalty of law (MCA 45-7-203), I certify that the statements made and information contained on this form are true and correct to the best of my knowledge, information, and belief; I am the person named on this form; and, if signing for a business entity or trust, I have full authority to do so.

Signature: _____
This is my legal signature Date

Printed name: _____



DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
For Adult and Youth Care Facility Providers
Criminal / Protective Service / Motor Vehicle
Background Checks

PERSONAL INFORMATION

Section A – Current Information

Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: Male Female Date of Birth: _____ Social Security # _____

Section B – Past Residences

Within the last five (5) years, have you...

1. ...lived in another state? Yes No

2. ...lived on or do you now live in an area designated as an Indian reservation? Yes No

If you answered yes to the any of the above questions:

- Please state where you have lived since turning 18 in the table below.
- You will need to obtain an out of state background check or a tribal background check at your cost.

City	County	Reservation	State	Dates of Residency (From – To)

Section D – Employment Status

The facility that I am working / living at is:

Director Name / Facility Name: _____

Facility Mailing Address: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Section E – Authorization Statement and Signature

I, _____ (applicant name), am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with my status as a current or prospective employee of or volunteer for that entity.

I am aware that CFSD, DMV, and DOJ records may contain information that could adversely affect my employment or volunteer status as outlined in ARM 37.97.101 through 37.97.132. These records will relate to any substantiated report(s) of child abuse or neglect in Montana, criminal history records, and motor vehicle records. As an employee or volunteer, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to _____ (provider or its authorized representative), and I **hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____
(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

Notary Public for the State of Montana

Residing at: _____

My commission expires: _____