DREAMS WITH WINGS

EMPOWERING CHILDREN AND ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES AND AUTISM

Application For Employment

Please print all information except signatures.

For Internal Use Only:

Supervisor _____

Position /Dept _____

Status FT ☐ PT ☐ HRS/WK _____

References Checked YES ☐ NO ☐ Initials _____

Face To Face Interview Date _____

Offer Position YES ☐ NO ☐ Rate _____

ED Approval YES ☐ NO ☐ Initials _____

Non-Discrimination Policy: Dreams With Wings is committed to the principle of equal opportunity in education and employment. Dreams With Wings Inc. does not discriminate against applicants or employees on the basis of sex, race, religion, national origin, ancestry or age. Dreams With Wings Inc. does not discriminate against qualified individuals with disabilities.

GENERAL INFORMATION

Date _____

Position Applied For _____ Date available to begin work _____

Work Preference FULL TIME ☐ PART TIME ☐ Are you willing to work a flexible schedule? YES ☐ NO ☐

Have you ever applied with DWW before? YES ☐ NO ☐ If yes, please provide date _____

Name (last, first, middle initial) _____

Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Email _____

- Are you over 18 years of age? YES ☐ NO ☐
- Are you a United States citizen? YES ☐ NO ☐
- If no, do you have a valid work permit? YES ☐ NO ☐

(Proof of citizenship or immigration status may be required upon employment)

DRIVER'S LICENSE/PERSONAL ID

Do you have a valid Driver's License? YES ☐ NO ☐

Are you applying for a position which will require driving? YES ☐ NO ☐ (If driving ,please complete driving release authorization)

Do you have adequate transportation? YES ☐ NO ☐

ID/Driver's License # _____ State of Issue _____ Expiration Date _____

***Some positions at DWW require driving and a Motor Vehicle Driving Record Check will be conducted.**

EDUCATION YOU WILL BE ASKED TO SUBMIT DOCUMENTATION OF HIGHEST LEVEL OF COMPLETED EDUCATION

	Name	Location	# of Years Completed	Graduated	Major
High School					
College					
Other					

Credentials YES ☐ NO ☐ If yes, please provide type _____

MILITARY

Are you a veteran of the United States military service? YES ☐ NO ☐ If yes, what branch? _____

Date Entered _____ Date Discharged _____

Describe any special skills or training acquired while in the enlisted _____

_____

WORK EXPERIENCE

Please list your last four (4) work experiences beginning with your **most recent** job.

Employer Name & Address	Dates of Employment	Job Title	Work Performed/Duties
	Supervisor	Reason for Leaving	
Rate of Pay: $			

Employer Name & Address	Dates of Employment	Job Title	Work Performed/Duties
	Supervisor	Reason for Leaving	
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Please list your last four (4) work experiences beginning with your **most recent** job.

Employer Name & Address	Dates of Employment	Job Title	Work Performed/Duties
Rate of Pay: $	Supervisor / Reason for Leaving		

Employer Name & Address	Dates of Employment	Job Title	Work Performed/Duties
Rate of Pay: $	Supervisor / Reason for Leaving		

REFERENCES **application MUST be returned with (one) 1 completed reference**, page 4. **ONLY PROFESSIONAL REFERENCES—SUPERVISOR OR HR DEPT.**

Name _____ Position _____

Relationship to Applicant _____ Phone/Email _____

Name _____ Position _____

Relationship to Applicant _____ Phone/Email _____

Name _____ Position _____

Relationship to Applicant _____ Phone/Email _____

I certify that all facts contained in the application are true and complete and acknowledge that Dreams With Wings Inc. is relying on the accuracy of the information provided. I authorize DWW to verify the accuracy of the information provided herein, and I authorize former employer, educational institutions and credit agencies to release information concerning me to DWW. I also authorize DWW Inc. to give references and provide information about me in response to inquiries subsequent to my employment if hired. I understand that falsification, misrepresentation, or omission of requested facts may result in denial of employment or, if employed, may result in immediate dismissal. I understand and agree that, if hired, my employment will be for no definite period and may regardless of the date of payment, and wages be terminated at any time without previous notice and without reason at the will of either myself or DWW Inc. I also understand and agree that no one has authority to promise me job security or continued employment, except the Executive Director of the agency in a formal written agreement signed by both of us.

Applicant Signature _____

Printed Name _____

Date _____

ADMINISTRATIVE OFFICE OF THE COURTS
RECORDS UNIT
1001 VANDALAY DRIVE
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
records@kycourts.net

The process to obtain the information contained in CourtNet is as follows:

Individuals

Requesting a record on yourself requires a $20.00 fee **(check or money order)**. If you do not receive a response in 30 days contact us at the number listed above.

Nonprofit/Commercial/Others

Requesting a record on individuals requires a $20.00 fee **(check or money order)**.

Fees are paid to the order of the KENTUCKY STATE TREASURER by check or money order ONLY. FAILURE TO COMPLY WITH THESE PROCEDURES WILL RESULT IN THE REQUEST BEING RETURNED UNPROCESSED. If you suspect information contained on the record is incorrect, or have any questions, please contact the Records Unit at (502) 573-1682 or (800) 928-6381.

PLEASE **PRINT OR TYPE** THE INDIVIDUAL'S INFORMATION **CLEARLY**.

SOCIAL SECURITY NUMBER: _____ DLN: _____

NAME: _____

MAIDEN NAME(S) AND/OR ALIAS: _____

DATE OF BIRTH: _____

STREET ADDRESS/P.O. BOX: _____

CITY, STATE, ZIP CODE: _____

I understand the information supplied by me must be truthful and falsification with an intent to mislead may result in my prosecution under KRS 523.100. I have provided the basic information necessary to qualify for record processing and exemption of fees - if applicable.

*** ALL INFORMATION BELOW IS REQUIRED.**

_____
Individual's Signature

_____
Date

_____
Company: Dreams With Wings, Inc.

_____
E-mail address

_____
Requestor/Contact Person

_____
Telephone Number 502-459-4647

_____
Address 1579 Bardstown Road

_____
City, State, Zip Louisville, KY 40205

Please denote which purpose applies to this request:

- ☐ Employment
- ☐ Criminal Investigation
- ☐ Screening Housing Applicants
- ☐ Volunteer/Care over Juvenile
- ☐ Licensing
- ☐ Other (please explain) _____

_____

Print Reset Form

POSITIONS WHICH REQUIRE DRIVING MUST COMPLETE THIS FORM

Dreams With Wings, Inc.
Dream Works, Inc.
1579 Bardstown Rd.
Louisville, KY 40205
502-459-4647
Fax-502-456-5705

Applicant Information Release

Consumer reports may be obtained as part of my employment with (the insured's name). The reports may be procured by DWW Insurer and may include my driving record, an assessment of my insurability under the Company's insurance coverage's or other consumer reports. By signing this disclosure, I hereby authorize the Company to procure such reports and additional reports about me from time-to-time, as it deems appropriate, to evaluate my insurability or for other permissible purposes.

Name (printed):_____

Address (printed):_____

_____
City State Zip

Signed_____ Date_____

State of License:_____ License #:_____

DOB _____ Expiration Date _____

Insurance Provider (Name, Agent, Phone) _____

Effective Dates _____

For Insurance Use Only:

This employee is eligible to operate a Dreams With Wings vehicle _____

This employee is **NOT** eligible to operate a Dreams With Wings vehicle _____

Signed _____ Date _____

DPP-156
(R. 1/18)
922 KAR 1:470

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

☐ Child-Placing Agency (Foster/Adoption/Independent Living) Employee or Volunteer (Required by 922 KAR 1:310)

☐ Residential Child-Caring Facility Employee or Volunteer (Required by 922 KAR 1:300)
(Institution/Group Home/Emergency/Wilderness)

☐ Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380)

☐ Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151)

☐ Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383)

☐ Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352)

☒ Supports for Community Living (SCL) Employee (Required by 907 KAR 1:145)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):

_____

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: _____
(first) (middle) (maiden/nickname) (last)

Sex: ___ Race: _____ Date of Birth: _____Social Security #:_____

Date of Initial Hire: _____

Present Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Previous Address: _____
City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.

CENTRAL REGISTRY CHECK

A check or money order made payable to the "Kentucky State Treasurer" in the amount of ten dollars ($10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment. Mail check or money order and this completed form to:

Cabinet for Health and Family Services
Department for Community Based Services
Records Management Section
275 East Main St., 3E-G
Frankfort, Kentucky 40621

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

_____ _____
Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

_____ _____
Witness Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF EMPLOYER/AGENCY: Dreams With Wings, Inc.

ADDRESS: 1579 Bardstown Road **CITY**: Louisville

STATE: KY **ZIP: 40205** **PHONE:** 502-459-4647

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]

☐ No reportable incident found in accordance with 922 KAR 1:470
☐ Substantiated child abuse found on the registry Date of substantiated finding: _____
☐ Substantiated child neglect found on the registry Date of substantiated finding: _____
The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights ☐ Yes ☐ No
☐ A matter subject to administrative review found in accordance with 922 KAR 1:470

CHECK CONDUCTED ON _____ **BY** _____

DPP-156
(R. 1/18)
922 KAR 1:470

Empowering Children & Adults with Intellectual Disabilities, Developmental Disabilities and Autism

Ebola Questionnaire

Questionnaire for new employees and recent travelers

1. Have you traveled to West Africa in an Ebola affected country in the last 21 days? (If no, then End questionnaire)

2. If yes, which country did you visit?

3. What date did you arrive back in the United States?

4. Have you contacted or been contacted by the local health department to begin the Ebola Post Arrival Monitoring process?

5. Can you provide proof that you have started the Post Arrival monitoring process?

- If YES, ask for a copy of their health order from the state health department
- If NO, then inform them that they must be excluded from work for 21 days from the date of arrival back into the United States.

1579 Bardstown Road
Louisville, KY 40205
(502)459-4647
www.dreamswithwings.org