DEPARTMENT OF FAMILY SERVICES CLARK COUNTY

CLARK COUNTY DEPARTMENT OF FAMILY SERVICES

121 South Martin Luther King Blvd
Las Vegas, Nevada 89106
(702) 455-7200

AGENCY STAFF APPLICATION PACKET

This application is for foster care Agency staff applying for clearance to work or applying for clearance in a licensed foster home. The application questions and requirements differ depending on the applicant's role so please only fill out the required sections.

Completed Application includes (copies of documents are acceptable):

1. Cover Sheet – fill in dates and information
2. Application for Agency Staff– complete all sections as applicable
    a. If applicant has any history of DFS Intake complaints, provide explanations of each. Copies of reports do not need to be submitted and are only needed if applicant cannot recall history.
        i. Contact DFS Records Department at (702) 455-6683 to obtain records if necessary.
    b. If applicant has any arrest history regardless of disposition, provide the following:
        i. Written explanation from applicant
        ii. Court disposition records
3. Signed Release of Information
4. NV Driver's License or NV Identification Card if non-driver—clear copy to show face
5. Copy of Social Security card
6. Training Log (for direct care applicants only)—Include completion certificates for online training
7. Degree/Diploma/Transcripts (if applicable)
8. Proof of verifiable experience (if applicable)
9. Tuberculosis (TB) test results
10. CPR card--Adult, Child and Infant CPR (for direct care applicants only) **cannot be from an online course
11. Proof of valid and current automobile insurance for any applicant who will drive children—(if applicant is only going to drive an Agency vehicle, need to indicate this on application)
12. Five (5) references, no more than two (2) related and all must have known applicant for at least two (2) years
13. Fingerprint receipt showing applicant printed for specific Agency

Application for Agency Staff Cover Sheet	Agency:
Name:	☐ Direct Care ☐ Non-Direct Care
Staff Position (for Agency Staff)	☐ Live In ☐ Non-Live In

DFS Completes this Section	Date Completed (DFS staff to enter)
Adam Walsh (State:)	
Fingerprinted	
Scope	
CANS	
A. Arrest history (If yes, provide B & C)	☐ Yes ☐ No
B. Explanation from applicant	☐ Yes ☐ No
C. Provide final disposition	☐ Yes ☐ No

Other:

	Expiration Date
NV Driver's License or ID Card	
TB Test Due Date	
CPR Due Date	
Auto Insurance Exp. Date	

Social Security Card	☐ Yes ☐ No
Training Log	☐ 40 ☐ 20
Release of Information	☐ Yes ☐ No
Degree/Diploma/Transcript (if applicable)	☐ Yes ☐ No
Verifiable Experience (if applicable)	☐ Yes ☐ No
Total Number of References:	Relative: Non:

***For Non-Direct Care applicants, no training log, CPR or auto insurance is required**

Perm Letter Sent:

If Denied, Denial Letter sent via Certified Mail on: / /

APPLICATION FOR AGENCY STAFF

AGENCY NAME:			
APPLICANT INFORMATION:			
Last Name:	First:	Alias:	☐Male ☐Female
Address (physical):	City:	State:	Zip:
Address (mailing):	City:	State:	Zip:
Telephone: ( ) -	Alternate Telephone: ( ) -		
Date of Birth:	Place of Birth - City:	State:	Country:
Social Security Number: - -			
Driver's License or ID Card: State:	Number:	Expiration Date:	
Highest Grade Completed in School:			
Race: ☐American Indian or Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian or Other Pacific Islander ☐White/Caucasian ☐Other (specify) If American Indian or Alaskan Native, provide tribal name and member number:			
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino			
Are you a US Citizen? ☐Yes ☐No			
If you are not a US Citizen, are you a Lawful Permanent Resident (LPR)? ☐Yes ☐No If yes, provide your Permanent Resident Card Number:			
Primary Language:	Do you speak English fluently? ☐Yes ☐No Other Languages spoken:		

RESIDENCE:

List the addresses where you have resided the last five (5) years. List most recent first.

Street	City	State	Zip	County	Dates From / To
					to
					to
					to
					to

REFERENCES: Please list five (5) references that have known you for at least two (2) years. No more than two (2) of the five (5) references may be relatives. Please be sure to include name and full mailing address including zip code. At least five (5) positive references are required for clearance.

Name	Relationship	Phone Number	Mailing Address or Email Address (please include zip codes)
		( ) -	
		( ) -	
		( ) -	
		( ) -	
		( ) -	

1. Have you ever worked in Child Welfare, Social Services, Mental Health or for a Foster Care Agency?

☐Yes ☐No If yes, list Agency, dates worked/licensed:

2. Do you now or have you ever provided care for any child that is not your own? ☐Yes ☐No
   a. If Yes, please answer the following:

Relationship to Child	Where Care was Provided	Hours per Week Care was Provided	Dates Care was Provided
			to
			to
			to

3. Do you now or have you ever had a Child Care License? ☐Yes ☐No
   a. If Yes, please answer the following:
      i. In what state(s):
      ii. Dates of licensure: to If currently licensed, attach copy of license to application.
4. Describe your general health (include any serious illnesses or disabilities).
   a. Do you have any history of mental illness, drug or alcohol addiction? ☐Yes ☐No
   If yes, please explain.
5. Are you or have you ever been prescribed any medications? ☐Yes ☐No If yes, table below must be completed. A note from attending physician may be required attesting to fitness for working with children.

Medication	Dosage	Prescribed by	Date Started & Discontinued
			TO
			TO
			TO

EMPLOYMENT HISTORY (Direct Care Applicants Only)

Please list your three (3) most recent places of employment.

Employed by	Type of Work	Hours of Work per Week	Phone Number	Dates of Employment
			( ) -	to
			( ) -	to
			( ) -	to

1. Give a brief statement as to your reasons for wanting to work with foster children.

2. Describe any experience you have working with children who have psychological or behavioral needs.

TRANSPORTATION (All Applicants):

Will you be responsible for providing transportation to counseling, medical appointments, visits with natural parents, school, etc.? ☐Yes ☐No

If No, you must attest to not drive foster children by checking this box. ☐ I agree

If Yes, submit copies of your active insurance card/policy showing you as a driver
Name of auto insurance and expiration date:

If Yes, but you will only be driving an Agency vehicle, please check here attesting that you will not use your own vehicle to drive foster children. ☐ I agree

BACKGROUND INFORMATION (All Applicants):

Have you **EVER** been arrested, charged, and/or convicted for ANY law enforcement violation? ☐Yes ☐No

a. If yes, please provide the specific details, listing ALL arrests, even if the charge(s) were later expunged or dismissed.
b. On a separate page, please provide date of arrest, circumstances and final dispositions. Also, provide copies that verify the final dispositions of the arrest.

Date of Arrest	Nature of Arrest/Crime	Final Outcome

Have you **EVER** had Child Protective Services, Licensing or Child Welfare Agency involvement for allegations of child abuse and/or neglect? ☐Yes ☐No

a. If Yes, please provide an explanation for each event on a separate page to include dates, circumstances, and results of any allegations made.

Date	Investigating Agency	Allegations	Outcome

I attest that the above information is complete and true to the best of my knowledge. Failure to disclose or answer the questions truthfully may result in an immediate denial of this application.

Printed Name _____ Signature _____ Date _____

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RELEASE OF INFORMATION

Regarding:

Agency Name:

Applicant Name:

Social Security Number of Applicant: - -

You are authorized by the undersigned to release to the Department of Family Services, the information including, but not limited to that indicated below. This authorization constitutes a full and complete release from any liability resulting from disclosure of such information. This authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

Data Requested (to be completed by Department of Family Services Representative):

Applicant Signature *Date*