IMPACT Plus
Behavioral Health Professional
New Employee/Contract Screening Form

Applicant Name: ______________________________ **Applicant Social Security #:** ____________________

Subprovider Name: ______________________________ **Applicant Date of Birth:** ____________________

Region(s) this applicant will be working: ______________________________

Please check all job descriptions that apply for this applicant (minimum of one box must be checked for Credentialing Committee to start review process):

- ❑ Individual Therapy
- ❑ Group Therapy
- ❑ Collateral Therapy
- ❑ Evaluation
- ❑ Targeted Case Manager Supervisor
- ❑ Therapeutic Child Support Supervisor
- ❑ Parent to Parent Supervisor
- ❑ Therapeutic After School Supervisor
- ❑ Summer Program Supervisor
- ❑ Children's Day Treatment Supervisor
- ❑ Intensive Outpatient Supervisor
- ❑ Therapeutic Foster Care Supervisor
- ❑ Group Residential Supervisor
- ❑ Crisis Stabilization Supervisor
- ❑ Partial Hospitalization Supervisor (Psychiatrist only)

Please check the appropriate license(s) for this applicant (minimum of one box must be checked for Credentialing Committee to start review process):

- ❑ Psychiatrist
  license number ____________________ expiration date ____________________
- ❑ Physician licensed in Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties
  license number ____________________ expiration date ____________________
- ❑ Psychologist licensed and practicing in accordance with KRS 319.050
  license number ____________________ expiration date ____________________
- ❑ Certified Psychologist with autonomous functioning or Licensed Psychological Practitioner certified and practicing in accordance with KRS 319.056
  license number ____________________ expiration date ____________________
- ❑ Clinical social worker licensed and practicing in accordance with KRS 335.100
  license number ____________________ expiration date ____________________
- ❑ Advanced registered nurse practitioner licensed and practicing in accordance with KRS 314.042
  license number ____________________ expiration date ____________________
- ❑ Marriage and Family therapist licensed and practicing in accordance with KRS 335.300
  license number ____________________ expiration date ____________________
- ❑ Professional Clinical Counselor licensed and practicing in accordance with KRS 335.500
  license number ____________________ expiration date ____________________
- ❑ Professional art therapist certified and practicing in accordance with KRS 309.130
  license number ____________________ expiration date ____________________
- ❑ Alcohol and drug counselor certified and practicing in accordance with KRS 309.080
  license number ____________________ expiration date ____________________

All of the following boxes must be checked verifying applicable information for each section is included with this form. The Credentialing Committee will not review packets that do not contain all of the required information.

- ❑ Current and legible copy of the applicant's pocket-sized license (or approval letter from Board if pocket-sized license has not been received)
- ❑ Professional liability insurance
- ❑ Current Department for Community Based Services criminal background check results
- ❑ Current Administrative Office of the Courts criminal background check results
- ❑ Current Statement of Disclosure signed by applicant and subprovider

Comments: ____

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In accordance with 907 KAR 3:030 and the IMPACT Plus Subprovider Agreement, the undersigned do hereby affirm all information related to this applicant has been reviewed for the Behavioral Health Professional position. References and other documentation submitted have been verified and the undersigned attest to it's accuracy.

In addition, we understand this applicant must be reviewed by the IMPACT Plus Credentialing Committee located in Frankfort, KY, and given "Approval" status before the delivery of IMPACT Plus services can be considered for Medicaid reimbursement.

Subprovider's Signature ____
Name Position Date

Applicant's Signature ____
Name Position Date

IMPACT Plus
New Employee/Contract Statement of Disclosure

907 KAR 3:030, Section 6 (3) IMPACT Plus Regulation

A subcontractor or person employed by a subcontractor to provide services pursuant to this administrative regulation shall not:

(a) Have been convicted of a felony offense;

(b) Have been convicted of a misdemeanor offense involving an illegal substance within the five (5) years previous to becoming a subcontractor or person employed by a subcontractor to provide services;

(c) Have been convicted of or have entered a plea of guilty to a sex crime as defined in KRS 17.165;

(d) Have been convicted as or have entered a plea of guilty as a "violent offender" as defined in KRS 17.165; or

(e) Have had an incident of abuse or neglect of a child or adult substantiated by the Cabinet for Families and Children after having been provided an opportunity to appeal the substantiation to an administrative or judicial body.

I do hereby affirm that I meet all of the conditions to provide services to IMPACT Plus recipients and families as specified in 907 KAR, Section 6 (3) above. I understand that dishonesty in my attesting of the above will result in immediate termination of status as an employee or contract employee of an IMPACT Plus subprovider.

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Applicant's Signature　　　　　　　　　　　　Date of Signature

As an IMPACT Plus subprovider,

(a) I understand that if the statement signed above by my employee or contract employee is found to be false:

i) I will ensure that he/she cease all contact with IMPACT Plus recipients and their families immediately;

ii) I will ensure continuity of care is being met by providing the recipients and their families "Freedom of Choice" for services; and

iii) I understand I am at risk of recoupment of payment for services rendered by the employee or contract employee.

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Subprovider's Signature　　　　　　　　　　　　Date of Signature

AOC-PT-49
Rev. 12-03
Page 1 of 1
www.courts.ky.gov

ADMINISTRATIVE OFFICE OF THE COURTS
PRETRIAL SERVICES RECORDS DIVISION
100 MILLCREEK PARK
FRANKFORT, KENTUCKY 40601
502-573-1682 or 800-928-6381
pretrialrecords@kycourts.net

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

Individuals — Requesting a record on yourself requires a $10.00 fee **(check or money order)**. Enclose a self addressed stamped envelope for a return reply.

Nonprofit
Health Care
Housing Auth. — Requesting a record on individuals requires a $10.00 fee **(check or money order)** and your nonprofit number (Form #51-A-126). Your return envelope must be addressed with adequate postage, and the other envelope only needs the address of the person being checked.

Licensing/ Others — A request for licensing purposes and on another person requires a $10.00 fee **(check or money order)** and must include two envelopes. Your return envelope must be addressed with adequate postage, and the other only needs the address of the person being checked.

Government — Government entities must provide both envelopes mentioned above, a tax exempt number for waiver of fees, contact person, phone number, and mailing address on their request. Multiple inquires can be made on a continuation form.

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 Pretrial Services Records Division at (502) 573-1682 or (800) 928-6381.

PLEASE PRINT OR TYPE THE INDIVIDUALS INFORMATION CLEARLY.

SOCIAL SECURITY NUMBER: ______

NAME: ______

DATE OF BIRTH: ______

MAIDEN OR ALIAS NAMES: ______

STREET ADDRESS / P.O. BOX: ______

CITY, STATE, ZIP CODE: ______

E-MAIL ADDRESS: ______

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**.

______
Individual's Signature

______
Date

D-280
Non-Profit Number (Form 51-A-126), or Tax Exempt Number

jvannevel@hollyhill-ky.org
E-mail address(sent to this e-mail only)

Would you like the CourtNet Records e-mailed? ☑ Yes ☐ No

Holly Hill Children's Services
Company

______
Telephone Number

Janet Van Nevel
Requestor/Contact Person

9599 Summer Hill Road
Address

California, KY 41007
City, State, Zip

Please denote which purpose applies to this request:
- ☑ Employment
- ☐ Criminal Investigation
- ☐ Screening Housing Applicants
- ☐ Volunteer/Care over Juvenile
- ☐ Licensing
- ☐ Other (please explain) ______

DPP-156
(R. 02/08)
922 KAR 1:470

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Protection and Permanency

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATIONS REQUIRE A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT. KENTUCKY ADMINISTRATIVE REGULATIONS MAY BE FOUND ON THE INTERNET AT http://www.lrc.ky.gov/kar/titles.htm. PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

Day Care Related Categories

- ☐ Day Care Center Employee or Volunteer (Required by 922 KAR 2:090)
- ☐ Applicant for Day Care Center Licensure (Required by 922 KAR 2:090)
- ☐ Registered Child Care Provider Applicant (Required by 922 KAR 2:180)

Other Categories

- ☐ Foster/Adoption/Independent Living Agency Employee (Required by 922 KAR 1:310)
- ☐ Residential Child-Caring Facility Employee (Institution/Group Home/Emergency/Wilderness) (Required by 922 KAR 1:300)
- ☒ IMPACT-PLUS Subcontractor (Required by 907 KAR 3:030)
- ☐ 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 to:

The Cabinet for Health and Family Services
DCBS/Division of Child Care
275 East Main St., 3C-F
Frankfort, Kentucky 40621

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and provide the results of the check 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 to disclose additional information regarding a substantiated 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.

NAME OF EMPLOYER/AGENCY: Holly Hill Children's Services

ADDRESS: 9599 Summer Hill Road **CITY:** California

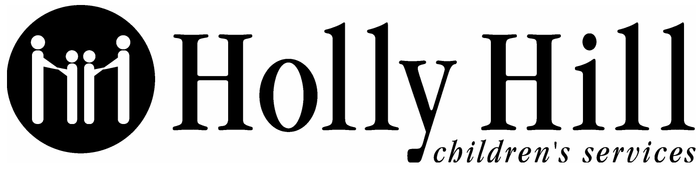
STATE: Kentucky **ZIP:** 41007 **PHONE:** (859) 635-0500, ext 214

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: __________

CHECK CONDUCTED ON __________ **BY** ____________________

DPP-156
(R. 02/08)
922 KAR 1:470



APPLICATION FOR EMPLOYMENT

9599 Summer Hill Road
California, KY 41007
(859) 635-0500 (859) 635-0504 Fax

Applications not signed and completed in full will be withdrawn from consideration.
Please print clearly.

Last Name First Middle	Date
Street Address	Home Telephone: ( )
City, State, Zip	Business Telephone ( )
Are you legally eligible for employment in the United States? (verification required) ☐Yes ☐ No	Former Names known by:
Have you ever applied for employment with us? ☐ Yes ☐ No If yes: Month and Year	Email:
Have you ever been employed with us before? ☐ Yes ☐ No If yes: Month and Year	Reason for Leaving:
Do you drive and have a valid driver's license? ☐ Yes ☐ No	List State and Number:
Have you had any traffic citations, excluding parking fines within the past two years? ☐ Yes ☐ No If yes, explain:	Are you over 21? ☐ Yes ☐ No
State any friends or relatives working for us, other than spouse.	
Have you been convicted of a crime which has not been annulled, expunged or sealed by a court? (A conviction record will not necessarily be a bar to employment. Factors such as age and time of the offense, seriousness, and nature of violation will be taken into account.) ☐ Yes ☐ No If yes, describe in full.	
In the past, have you ever failed a drug test or been discharged from a job because of illegal drugs? ☐ Yes ☐ No If yes, describe in full.	

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, or any other legally protected status.

Position(s) Applied for:	
Are you available for work? ☐ Full-time ☐ Part-time ☐ Temporary	Will you work overtime if asked? ☐ Yes ☐ No
Can you work shift work? ☐ Yes ☐ No If yes, shifts preferred:	When will you be available to work?
Are you able to meet the attendance requirements of the job? ☐ Yes ☐ No	

School	Name and Location of School	Course of Study	No. of Years Completed	Did you Graduate?	Degree or Diploma
High School					
College					
Graduate					
Other (Specify)					

Describe other special training, skills, licenses and/or certificates related to the job for which you are applying.

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Employment Experience

Start with your present or last job. Include job-related military service assignment and volunteer activities. You may exclude organizations, which indicate race, color, religion, gender, national origin, disabilities or other protected status.

Employer	Telephone ( )	
Address	Employed (state month & year)	
	From:	To:
Name of Supervisor	Weekly Pay	
	Start	Last
State Job Title & Describe Your Work	Reason for Leaving	
Employer	Telephone ( )	
Address	Employed (state month & year)	
	From:	To:
Name of Supervisor	Weekly Pay	
	Start	Last
State Job Title & Describe Your Work	Reason for Leaving	
Employer	Telephone ( )	
Address	Employed (state month & year)	
	From:	To:
Name of Supervisor	Weekly Pay	
	Start	Last
State Job Title & Describe Your Work	Reason for Leaving	
Employer	Telephone ( )	
Address	Employed (state month & year)	
	From:	To:
Name of Supervisor	Weekly Pay	
	Start	Last
State Job Title & Describe Your Work	Reason for Leaving	

We may contact the employers listed above unless you indicate those you do not want us to contact.	DO NOT CONTACT Employer Number(s) ___________________________________ Reason: ____

PERSONAL REFERENCES: (former co-workers preferred, please list one close family member)			
Name:	Relationship	Address	Phone Number

The facts given in my application for employment are true and complete to the best of my knowledge. I understand that if I am employed, any false statement, misleading information or material omission on this application or given in an interview may be sufficient cause for cancellation of this application or immediate discharge from employment regardless of when such information is discovered.

I further understand and acknowledge that, unless otherwise defined by applicable law, that any employment relationship is at-will and can be terminated by either party with or without notice, at any time, for any reason or no reason. This application does not constitute an agreement or contract for employment for any specified period or definite duration. I understand that only an authorized officer of the agency has the authority to make any agreement contrary to the foregoing. I further understand that such assurances must be in writing and signed by an authorized officer.

I authorize any investigation of statements contained in this application for employment. The agency may receive a report from an investigative consumer agency to obtain information on my credit and personal history. At my request, the agency must provide the name of the investigative consumer agency so that I may obtain from them the nature and substance of the information contained in the report. I hereby release from liability the agency and its representatives for seeking, gathering and using such information and all other persons, corporations or organization for furnishing such information.

I also understand that if I am hired, I am required to abide by all policies rules and regulations of the agency as currently stated or issued in the future and acknowledge that they are subject to change at the agency's sole discretion. I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization. I consent to undertake a medical exam and/or drug testing after a conditional offer of employment has been made.

__________________________________ ________________________

Signature of Applicant Date