SYNERGY SERVICES
Synergy House • SafeHaven • STOP Violence
400 E. Sixth Street • Parkville, MO 64152

VOLUNTEER APPLICATION CHECKLIST

The following items must be received before application can be processed:

☐ Volunteer Application

☐ Confidentiality Agreement

☐ Missouri & Kansas background screenings
Synergy Services requires background screenings for both Missouri and Kansas.

☐ Copy of Current Driver License

☐ Copy of Social Security Card

☐ Finger Printing Waivers
Synergy Services requires all volunteers to be fingerprinted

☐ $50.00 Application Fee

PAYMENT INFORMATION

☐ I prefer to donate online at www.SynergyServices.org

☐ My check for $_____ is enclosed (payable to Synergy Services)

☐ (circle one) Visa Master Card Discover

Please charge my credit card in the amount of $_____

Card Number _____CVVS _____ Exp. Date _____

Name on Card _____

Billing Address _____

City_____ ST _____ Zip _____

Signature _____

Please mail or fax
Synergy Services
400 E. 6th Street
Parkville, MO 64152
Fax 816-587-6691

For questions contact Corky McCaffrey 816-505-4945
or cmccaffrey@synergyservices.org

Thank you!

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VOLUNTEER APPLICATION

Thank you for taking the time to fill out this application. The information you provide will assist us in placing you in an appropriate volunteer opportunity that will match your skills and interests.

Name: _____ Age if under 18: _____ Birthday: M_____D_____

Mailing Address _____
Street City State Zip

Telephone: _____ E-mail: _____

Drivers License State & # (copy is required):_____

Person to contact in case of an emergency: _____ Phone: _____

Please use the back of the page for any additional information to the following questions:

Are you currently employed and/or in school? If so where? _____

_____

Previous or Related Experience (work, school, volunteer): _____

_____

How did you become interested in Synergy and what prompted you to become involved as a volunteer? _____

_____

When are you available to volunteer (days of week & times)? How many hours per week/day are you available to volunteer? Please be as specific as possible. _____

_____

Special or technical skills or training: _____

_____

Are you associated with any Professional/Civic Organizations, clubs or organized groups? Please list:

_____

_____

Are you a member of **Synergy's Circle of Friends**? □Yes □No
If not, are you interested in learning more about the opportunity? □Yes □No

Areas of Interest
If possible, please indicate which opportunities you are most interested in:

Direct – Client Support Services (see job descriptions for details)

□ Advocacy (Tutoring, YRC, General) □ Child Care □ Hotline/Intake Advocate

□ Mentoring (Parenting Teens, Women, Children) □ Outreach (Community Info/Special events)

□ Preparing/Cooking Meals □ Teaching groups (Life Skills, recreation, art, cooking, etc)

□ Women's Advocate □ Other _____

continued

Indirect – Support Services

□ Clerical support (administrative duties, office aide, data entry, reception) □ Fundraising

□ House Keeping (cleaning and organizing) □ Public education and promotions □ Speakers Bureau

□ Special events □ Thrift Store (sorting, tagging, transporting items) □ Yard work

□ Special project in/around the building (painting, organizing, etc) □ Other _____

Please check skills and Interests that you would be willing to share in your volunteer experience:

□ Artistic	□ Bilingual	□ Career building/Resume	□ Carpentry
□ Cleaning	□ Data Entry	□ Decorating	□Event Planning
□ Filing	□ Fundraising	□ Gardening	□ Grant Writing
□ Group Facilitation	□ Hair Styling	□ Heavy Lifting	□ Landscaping
□ Legal Advice	□ Microsoft Access / Excel / Publisher / Word (circle one or more)		
□ Organizing	□ Parenting	□ Phone skills	□ Public Speaking
□ Sorting donations	□ Sewing/alterations	□ Transport Safe Place Youth	
□ Sign Language	□ Other _____		

References (please provide two references)

1. _____
Name Relationship Telephone

_____
Address City State Zip Email

2. _____
Name Relationship Telephone

_____
Address City State Zip Email

Authorization and Acknowledgement for release of information

I acknowledge that Synergy Services, Inc. and/or its agents may investigate any information that it believes is business relevant including, but not limited to, employment history, educational background, criminal records, child abuse/neglect screening, police screening and driving record. I release any employees and persons named herein from all liabilities for any and all damages resulting from the furnishing and release of such information.

I also authorize my former employers, schools and personal references to provide any information that would be relevant to performing the volunteer position they may have regarding me, whether or not it is in their records. I hereby release them and their company from all liability for divulging same.

_____ _____ _____
Signature Printed Name Date

Thank you for your interest in Synergy Services, Inc. We understand there are many opportunities in the community for you to volunteer your time and talents. We appreciate that you chose Synergy and it is important to us that the experience will be mutually positive and rewarding.

Mission Statement

"The Mission of Synergy Services is to strengthen the individual, family, and community through crisis intervention, shelter, counseling, advocacy, and education."

Synergy Services, Inc.
400 E. Sixth Street • Parkville, MO 64152

CONFIDENTIALITY AGREEMENT

The mission of Synergy Services, Inc. is to eliminate family violence, abuse and neglect by providing quality services for persons of all ages. We seek to empower the individual, strengthen the family, and develop our community through crisis intervention, shelter, counseling, advocacy and education.

Please initial each item and sign below to confirm your understanding and agreement. This Confidentiality Agreement is required of all board members, employees, independent contractors or business associates, and volunteers of Synergy Services, Inc.

_____ Confidentiality of DV Shelter Location:

My initials indicate that I understand the importance of safeguarding the location of Synergy Service's domestic violence shelters. The confidentiality of domestic violence shelter locations is essential for maintaining the safety and well being of battered women and their children.

I agree to not divulge the location of the domestic violence shelters except as necessary to conduct normal business operations. In the event that the location must be revealed, I agree to inform the party receiving the information about this policy and the need for confidentiality.

_____ Confidentiality of Client Information:

My initials indicate that I understand the importance of safeguarding the protected health information, including the identity, of clients of Synergy Services. I agree to take responsibility for the protection of client information and acknowledge that I am subject to sanctions and possible dismissal if involved in compromising client confidentiality.

Signature: _____ Date: _____

Name: _____
Please Print

Organization: _____
If Applicable

Witness: _____

Missouri Department of Health and Senior Services
Family Care Safety Registry

RESET

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent (Agency Name: _____)
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent (County Office: _____)
- ☐ Hospital
- ☐ Long Term Care/Personal Care *(Please choose subcategory at right →.)*
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary *(Select voluntary if no other registration type applies.)*

A one-time registration fee of **$10.00** applies to all categories except Foster Parents. Foster Parents must list the agency or county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

Long Term Care / Personal Care Subcategories
(Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (If applicable.)

OTHER NAMES USED (If applicable. Include other last names, other first names, nicknames.)	DATE OF BIRTH (mm/dd/yyyy)	GENDER
	/ /	☐ M ☐ F

CONTACT INFORMATION

STREET ADDRESS (Must be different from Employer Street Address.)

ADDRESS LINE 2 OR PO BOX (If applicable. This line of the address must reflect where you receive your mail.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL (Optional)	COUNTRY (Complete only if U.S. territory or outside U.S.)
( ) -		

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER STREET ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
( ) -		

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ Other (Explain: _____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requestor of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (Must be signed in blue or black ink.)	DATE OF SIGNATURE (Must be within six months of submission.)
➤	/ /

Kansas Department of Social and Rehabilitation Services Child Abuse and Neglect Central Registry 915 SW Harrison 5th Fl. South Topeka, Kansas 66612	Child Abuse and Neglect Central Registry **Release of Information**

I, _____, give permission for the release of any information concerning
(please print complete first, middle and last name)
myself in the Child Abuse and Neglect Central Registry to:

Contact Person: Corky McCaffrey

Agency Name: Synergy Services

Mailing address: 400 E. 6th St.

Parkville, MO, 64152

Phone Number (816) 505-4945

I understand that all information released will be for the exclusive and confidential use of the above named organization/person/agency.

**** Please complete the information below by printing in ink. Please print legibly. Do not leave any space blank. All requested information is required to process this request. Incomplete information will result in the release not being processed and will be returned as insufficient.****

First, Middle and Last Name: _____

Maiden Name: (Female applicant only) _____

Married Names, Nicknames or Other Names Used:
(Use N/A if no other names used) _____

Date of Birth: _____ Race: _____

Social Security # _____ Gender: ☐ Male ☐ Female

Signature: _____ Date: _____

Current Address: _____

_____

Each request must be submitted with payment prior to the request being processed. Please attach appropriate fee of $10.00 per release of information. All releases and fees should be sent via postal mail to the attention of SRS, Child Abuse and Neglect Central Registry, P.O. Box 2637, Topeka, KS 66601. The following state agencies are exempt from the $10.00 fee: JJA (Central Office or Facilities), KNI, Dept. Of Education- Central Office, KDHE, State Hospitals, State Correctional Institutions, Attorney General's Office, Kansas School for the Blind, Kansas School for the Deaf, Child Welfare agencies in other states. Mentor record checks, i.e. Big Brothers Big Sisters, are exempt from the $10.00 fee. For a complete list of Mentor Programs, go to: http://kansasmentors.kansas.gov/Pages/FindaProgram.aspx. If this is a mentor record check, please make sure the box below is checked.

Mentor Program: ☐ If yes, please check

For Central Registry Use Only

_____ FEE ATTACHED

NONCRIMINALJUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification' that your fingerprints will be used to check the criminal history record of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license or other benefit based on information in the criminal history record. [2]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.'

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov /about-us/ciis/ba ckground-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

Name: _____ Date: ----------

_____

[1] Written notification includes electronic notification, but excludes oral notification.

[2] See 28 CFR 50.12(b).

[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

Missouri State Highway Patrol
Criminal Justice Information Services Division

MoVECHS WAIVER AGREEMENT AND STATEMENT

Missouri Volunteer and Employee Criminal History Service (MoVECHS)

For Criminal **History** Record Checks under the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA)

Pursuant to the National Child Protection Act of 1993 (NCPA), as amended by the Volunteers for Children Act (VCA), this form must be completed and signed by every current or prospective applicant, employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize, SYNERGY SERVICES
Name of Qualified Entity

to submit a set of my fingerprints to the Missouri State Highway Patrol (MSHP) for the purpose of accessing and reviewing Missouri open and closed criminal history records and national criminal history records that may pertain to me. I understand that I would be able to receive any Missouri records pursuant to 43.540 RSMo from the MSHP, and any national criminal history record directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any Missouri and national criminal history record that may pertain to me to the qualified entity.

I understand that, until the criminal history background check is completed, the qualified entity may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, the qualified entity will provide me a copy of the criminal history background report, if any, received on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made.

☐ **YES, I have** (or) ☐ **NO**, I have not been convicted of or plead guilty to a crime.

If yes, describe the crime(s) and the particulars in the space below:

I am a current or prospective (check one): Applicant ☐ **Employee** ☐ **Volunteer** ☐ **Contractor/Vendor** ☐

Signature: **Date:** _____

Printed Name: _____

Address: _____

Date of Birth: _____ Social Security No. _____

☐ **YES** ☐ **NO** The Qualified Entity may share my Criminal History Record Information with other approved Missouri Qualified Entities. The sharing of information between agencies must be in accordance with State and Federal law.

TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: SYNERGY SERVICES

Address: 400 East 6th Street, Parkville, MO

Telephone: 816-587-4100 Fax: 816-505-7176

MSHP Assigned Qualified Entity Number:

ORIGINAL- RETAINED BY QUALIFIED ENTITY

FINGERPRINTING PROCEDURE

1) Please review the document below for instructions to schedule your fingerprinting appointment.

2) Once you begin the process, you will be asked for a 4 digit registration number which is **5943.**

3) Continue with the enrollment process to schedule your appointment.

MISSOURI APPLICANT PROCESSING SERVICES APPLICANT USER GUIDE FOR STATE AGENCY AND MOVECHS FINGERPRINT SEARCH REQUESTS

To begin the registration process with MACHS, go to www.machs.mo.gov and click the icon to access the MACHS Fingerprint Portal.

Select the option requiring the 4 digit registration number to begin your registration process.

At the top of the registration page you should enter your 4 digit registration number in the space provided. Clicking "Populate" will automatically return a message displaying the name and identifying information of the employer/licensing agency to verify that you are using the correct registration number.

Once you have verified your agency information you may begin entering your personal demographic data into the spaces provided. Mandatory fields are marked by a red *. When you are finished click "Register".

At the top of the verification page an 8 digit Transaction Control Number (TCN) will be highlighted. This number will be used to track your fingerprints through the background check process.

During registration you will be asked if your background check is being conducted for a position as a volunteer. Be sure to answer this question correctly so that MACHS can use the correct search type and fee for your purpose.

Print the Transaction Information screen. Contact one of the fingerprint service sites by phone to schedule your appointment. They will ask for your Transaction Control Number (TCN).

SITE INFORMATION

Primary Service Location Address	**Goin Postal** 7701 NW Prairie View Rd. Kansas City, MO 64152
Hours of Operations	Monday – Friday 9:00 am – 6:00 pm Saturday 10:00 am – 2:00 pm CLOSED SUNDAYS httns://Qoinnostalkansascitv.acuitvscheduJinq.com/
Telephone Number (Applicant Use)	Beverly G. Dirck 816-505-4700
Web Site	
Directions to your facility	Map it 1-29 North toward KCI airport. Left on 72nd St. RT. On Prairie View Rd to address.
Additional Information	

Primary Service Location Address	**UPS Store 4799** 105 S. Jefferson St. Suite C-3 Kearney, MO 64060
Hours of Operations	Monday- Friday 8:00am – 7:00pm Saturday 9:00am – 5:00pm Closed Sunday
Telephone Number (Applicant Use)	Bob Tate 816-903-4877 Store4799@theuosstore.com
Web Site	
Directions to your facility	Map it Exit 1-35 turn east 2nd stoplight turn left on MO 33/Jefferson St. Approx. three blocks north turn in to Old Church Plaza
Additional Information	