Fiscal Management Services
504 Miller Drive PO Box 408 Wamego KS 66547
785- 456-8573 785-456-9915 TEXT Line: 844-617-9689

Direct Service Worker Application Packet

3Rivers Financial Management Services (FMS) connects compassionate, dependable individuals with Consumers enrolled in 3Rivers' services. 3Rivers **does not** employ or place Direct Service Workers; we serve as payroll agent on behalf of our Consumers, who are tasked with employing and directing their workers.

Please review and complete all sections of the attached application.

Position Requirements:

- Must be 18 years of age or older
- Access to reliable transportation
- Clearance of Background Checks – **There is a $20.00 charge for background checks which must be included with your application.**

Required Documents:

- Copy of Valid Driver's license or State ID (front and back)
- Copy of Social Security card (front and back)

ATTENTION! ALL FORMS OF ID **MUST** REFLECT YOUR LEGAL NAME/IDENTITY.
Failure to provide these documents will prevent the completion of your application until received.

Additional Information:

- Experience preferred
- High School Diploma or GED preferred
- Use secure mobile app on your phone for time tracking

Items to return include:

- Completed Application
- Copy of current Driver's License, or State ID (front and back)
- Copy of Social Security card (front and back)
- $20.00 Background Check fee – **pay by cash, check, or credit/debit card.**

Email, Fax, Mail, or Drop Off application when completed.

Make Checks Payable to

Three Rivers Inc.
504 Miller Dr
PO Box 408
Wamego, KS 66547

or Contact 3Rivers FMS team to pay by card.

NOTE: You are not eligible to work until background checks are completed. You will be notified when you are eligible to work in a Medicaid funded program, typically two weeks from submittal date. KS Statute 39-2009 specifies adverse findings and offenses that would prevent someone from qualifying; you may request additional information by contacting the FMS team at 3Rivers.

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Complete All Information Below. Information Must Match Your Social Security Card

Note: 3Rivers neither employes nor places in home workers. 3Rivers serves as a payroll agent for individuals seeking in-home workers. 3Rivers processes applications, manages payroll duties and maintains a registry of qualified workers.

NAME _____ **DATE OF BIRTH** ____/___/____
Last **First** **Middle**

ADDRESS: _____

CITY: _____**STATE:** _____ **ZIP:** _____ **COUNTY:** _____

SOCIAL SECURITY NUMBER: _____ **CELL PHONE: (_____)** _____

Do you agree to opt in for text messaging? YES _____ NO _____ (You can opt out anytime by replying STOP)

EMAIL ADDRESS: _____ **HOME PHONE:(_____)_____**

EMERGENCY CONTACT PERSON: _____ **PHONE: (_____)** _____

☐ Yes ☐ No Have you graduated from high school or received a GED Certificate?
☐ Yes ☐ No Are you legally permitted to work in the United States?
☐ Yes ☐ No Do you have a valid driver's license? By completing this application you are authorizing Three Rivers to run a check with the state of issue for violations on your driving record.*
☐ Yes ☐ No **If yes, do you maintain the necessary auto liability insurance as required by the state of Kansas?*
☐ Yes ☐ No **If yes, are you willing and able to provide transportation for your consumer/employer?*
☐ Yes ☐ No Have you ever been convicted of a felony? If yes, what state(s) _____ (certain convictions will prohibit you from being hired)
☐ Yes ☐ No Do you have a current CNA or CMA license? If yes, please attach certificate to application.
☐ Yes ☐ No Duties of a Direct Service Worker often require ability to lift a minimum of 25 lbs. Do you have any limitations that a Consumer should be aware of? If yes, please explain: _____
_____
☐ Yes ☐ No Have you been enrolled with 3Rivers Financial Management Services under a different name? If yes, previous name: _____
☐ Yes ☐ No Direct Service Worker Registry – Three Rivers, Inc. maintains a list of workers that is handed out to our Consumers seeking new Direct Service Workers. Would you like to be included on this list?

If you are completing this application to work for a particular Consumer, please provide us their name:

_____

Application and required documents should be returned to:
Three Rivers, Inc., Fiscal Agent
Attn: FMS
P.O. Box 408
Wamego, Kansas 66547-0408

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Memorandum of Understanding Between 3Rivers Fiscal Agent and the Direct Service Worker

What are SELF-DIRECTED SERVICES?

Under Kansas Medicaid rules, qualifying individuals (known as Consumers) can self-direct their services to assist them in living independently in their homes. The Consumer you are enrolling to work for has chosen this option and will direct you in all aspects of your work. The Consumer – your employer – is responsible for hiring, training, scheduling, monitoring, and terminating their employees. Individuals in Self-Directed programs have plans of care that outline services allowed, with weekly and monthly caps on allowable hours.

How is Three Rivers, Inc., Fiscal Agent involved?

3Rivers Fiscal Agent (FA) has been selected by your employer to provide payroll and financial management services (FMS) on their behalf. 3Rivers processes required financial and human resources paperwork necessary for your employment. On behalf of your employer, 3Rivers FA will assist you with paperwork, training for timekeeping systems, and will process payroll for authorized hours of work.

3Rivers FA neither hires nor places workers.

Please initial beside each below. Three Rivers, Inc., Fiscal Agent Expectations as your Payroll agent:

_____I understand that the Consumer for whom I am working is my employer/supervisor and is responsible for training, scheduling, terminating employment, and monitoring my time worked.

_____I am responsible for discussing employment disputes, including wage disputes, with my employer. My employer may ask me to contact 3Rivers FA staff for specific information and to provide me additional training.

_____I am responsible for notifying 3Rivers FA of any relationship to/for the person I work for, including guardian, conservator, personal representative, payee, or durable power of attorney. Failure to disclose this information may lead to recoupment of wages and/or termination.

_____I will NOT share medical/personal information about my employer without a signed release by my employer allowing me to share specific information. This includes talking to family and friends of my employer.

_____I understand I am an "employee-at-will" and may be terminated with or without cause.

_____I understand falsifying documents or AuthentiCare time tracking will be reported to authorities as attempted Medicaid Fraud prosecutable through the Kansas Attorney General's Office.

_____I understand 3Rivers FA is not authorized to pay me for hours worked outside the scope of my employer's Plan of Care developed with their insurance provider. I understand my employer must be present while I'm working. ***Employers are responsible for DSW wages for hours worked beyond or outside their plan of care.***

_____ _____

Direct Service Worker Signature **Date**

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Termination Notification Policy

_____As a Direct Service Worker, I understand I am employed by the participant enrolled in 3Rivers financial management services program *and* that 3Rivers' FMS team manages unemployment claims with, and on behalf, of the participant, THEREFORE,

_____ I understand if for any reason my employment ends with this participant; I WILL contact 3Rivers' FMS at 785-456-8573 ***within 3 days***.

Failure to contact 3Rivers will indicate that I am no longer interested in providing personal services for participants enrolled with this payroll agency, *and* that I do not wish to remain on the worker registry list provided to Three Rivers' consumers seeking workers.

_____ _____

Direct Service Worker Signature **Date**

My Signature Indicates I have read and understand the above employment notification policy.

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Direct Service Worker
Mandatory Use of AuthentiCare
For Medicaid Funded In Home Services (HCBS)

What is AuthentiCare?

AuthentiCare is an Electronic Verification System that Direct Service Workers (DSW) use to clock in and out when providing services for your Consumer/employer as outlined in their care plan.

Use of AuthentiCare:

DSWs and employers are **REQUIRED** by the state of Kansas to use this service to document time worked for HCBS Consumers. Failure to do so may result in the termination of the employer's right to self-direct their Medicaid funded services or a termination of all services.

Kansas Medicaid funded services, requires the HCBS Consumer/employer to have a landline phone for the DSW to call into the AuthentiCare system, **OR**, the DSW can download the AuthentiCare mobile app on their (the DSW's) smartphone. Again, the use of AuthentiCare is mandatory for HCBS participants.

The AuthentiCare system rounds time worked to the nearest 15-minute interval. For example, if you clock out at 7:06pm, AuthentiCare will round back to a 7:00pm clock out time. If you clock out at 7:08pm, AuthentiCare will round up to a 7:15pm clock out time. This occurs during both clock in and clock out. The system will provide a report of time used so Consumers and DSW's can monitor this. 3Rivers provides training on this system.

What if a clock in and/or out is missed?

If a clock in and/or out is missed, your employer should immediately contact 3Rivers to report your time worked and duties performed. *Call 785-456-9915 option #3 to report this information.*
3Rivers FMS department may request a signed timesheet to verify this information.

Hours of Work and Pay Schedule:

- *Your employer's care plan guides approved duties and does not cover overtime wages*!
- Your employer's care plan has weekly limits and monthly limits. You should carefully track your time
- 3Rivers is not authorized to pay DSWs for hours worked over these weekly/monthly units, if you work hours beyond the care plan allowance, your Consumer/Employer is responsible for payment.
- You are responsible for discussing your work schedule with your employer and any planned absences should be approved by your employer.
- A pay week starts on Sunday and ends on Saturday. Workers are paid every other Friday.

_____ _____

Direct Service Worker Signature **Date**

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By accepting Medicaid Funds, you agree to use those funds only in the manner for which they were intended. You need to be alert to any signs of potential Medicaid Fraud. Medicaid Fraud is committed when a CONSUMER, WORKER or PROVIDER intentionally submits false information to the Medicaid program about services rendered to Medicaid recipients.

Medicaid Fraud includes:

- Claiming time worked when the consumer is out of the home due to hospitalization, nursing facility, rehabilitation facility or incarceration (jail or prison)
- DSWs (Direct Support Workers) submitting time when not actually working
- Employers/consumers submitting time for a worker who is not working
- Using someone else's worker ID to submit time
- Submitting incorrect dates and times for services performed
- Submitting overlapping hours for two or more Medicaid beneficiaries for the same time period
- Submitting time to Medicaid and accepting private pay from another source for the same service
- Submitting time for performing tasks not on the authorized Plan of Care/Service Plan
- Submitting time for activities not provided
- Giving or accepting "kickbacks" (something of value in return for receiving services)
- Knowingly submitting false information
- Splitting paychecks with your worker

There are serious consequences for committing Medicaid Fraud:

- Arrest and prosecution, criminal penalties, fines and jail time
- Civil damages and monetary penalties
- Termination of Medicaid Provider Services
- Exclusion from working in any facility receiving federal health care funds
- Loss of certification (e.g. CNA, LPN, RN, etc.)

To report suspected Medicaid Fraud immediately notify 3Rivers or contact the Attorney General's office at 1-866-551-6328 or 785-368-6220.

Retaliation against any individual who reports suspected Fraud or participates in an investigation of such reports (referred to as whistleblowing) is strictly prohibited by law.

I have read and understand this information regarding Medicaid Fraud. By accepting services paid with Medicaid funds or accepting pay for providing services paid with Medicaid funds, I agree that if I intentionally commit any of the above mentioned acts, the suspected Medicaid Fraudulent activity will be reported to the Kansas Attorney General's office for investigation and potential prosecution.

_____ _____

Direct Support Worker's Signature Date

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General Policy

Abuse, Neglect and Exploitation

All participant, direct service workers, and Three Rivers, Inc., Fiscal Agent employees' reserve the right and responsibility to report to the state of Kansas any suspected abuse, neglect, or exploitation. If you suspect a participant is being abused, neglected, or exploited, you will contact the *Kansas Protection Report Center* at 1-800-922-5330. Your identity will be kept confidential. The Kansas Protection Report Center is staffed 24 hours a day. In the event of an emergency, call 911. If Medicaid fraud or abuse is suspected, you will report it immediately to 1-866-551-6328.

Injury in the Workplace Must Be Reported Immediately

If you are injured while working for a participant and require immediate medical attention, go to the nearest emergency room. You are required to submit to drug-testing at the time of your treatment. Failure to submit to drug-testing may be grounds for termination. You, or the participant on your behalf, must contact the Three Rivers, Inc. FMS at 785-456-8573 regarding the injury within 24 hours, regardless of if the timeframe falling on a weekend or holiday. If the FMS Coordinator is unavailable, you must leave a detailed message. You will be contacted by the FMS Coordinator within one business day.

Additionally, you are responsible to:

- Ensure the hospital/clinic/doctor's office is informed the injury occurred on the job and related medical bills should be sent to Three Rivers, Inc., Fiscal Agent.
- Complete an *Employee's Report of Accident* form and an *Authorization Form for Release of Protected Health Information* (supplied by Three Rivers, Inc.) and return them to Three Rivers, Inc. as soon as possible, but no later than one week from the date of accident.
- Request any witness/witness' complete an Accident Witness Statement and send it to Three Rivers, Inc.

Three Rivers, Inc., Fiscal Agent reserves the right to determine your treating physician. Your privilege preventing the furnishing of medical information is waived when seeking worker's compensation benefits. Unreasonable refusal to cooperate may result in compensation being denied or terminated. All alleged violations, including fraud or abusive acts, with regards to the *Worker's Compensation Act* will be reported immediately to the Kansas Division of Worker's Compensation Ombudsman/Claims Advisory Unit for answers to questions, assistance with claim information and problems by calling toll free 1-800-332-0353.

_____ _____

Direct Service Worker Signature **Date**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

K-4
(Rev. 7-24)

KANSAS
EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

K-4 Attach 500524

Use the following instructions to accurately complete your K-4 form, then detach the lower portion and give it to your employer. For assistance, call the Kansas Department of Revenue at 785-368-8222.

Purpose of the K-4 form: A completed withholding allowance certificate will let your employer know how much *Kansas* income tax should be withheld from your pay on income you earn from Kansas sources. Because your tax situation may change, you may want to re-figure your withholding each year.

Exemption from Kansas withholding: To qualify for exempt status you must verify with the Kansas Department of Revenue that: **1)** last year you had the right to a refund of ***all*** STATE income tax withheld because you had ***no*** tax liability; and **2)** this year you will receive a full refund of ***all*** STATE income tax withheld because you will have ***no*** tax liability.

Basic Instructions: If you are not exempt, complete the **Personal Allowance Worksheet** that follows. The total on line F should ***not*** exceed the total exemptions you claim under "Exemptions and Dependents" on your Kansas income tax return.

NOTE*: Your status of "Single" or "Joint" may differ from your status claimed on your federal form W-4).*

Using the information from your **Personal Allowance Worksheet**, complete the **K-4** form below, sign it and provide it to your employer. If your employer does not receive a K-4 form from you, they must withhold Kansas income tax from your wages without exemption at the "Single" allowance rate.

Head of household: Generally, you may claim head of household filing status on your tax return only if you are **unmarried and pay more than 50% of the cost of keeping up a home for yourself and for your dependent(s).**

Non-wage income: If you have a large amount of non-wage Kansas source income, such as interest or dividends, consider making Kansas estimated tax payments on Form K-40ES. Without these payments, you may owe additional Kansas tax when you file your state income tax return.

Personal Allowance Worksheet

A Allowance Rate: If you are a single filer mark "Single" — **A** ☐ Single
If you are married and your spouse has income mark "Single" — ☐ Joint
If you are married and your spouse does not have income mark "Joint"

B Enter "0" or "1" if you are married or single(entering "0" may help you avoid having too little tax withheld) ..... **B** _____

C Enter "0" or "1" if you are married and only have one job, and your spouse does not work (entering "0" may help you avoid having too little tax withheld) ..... **C** _____

D. Enter "2" if you will file head of household on your tax return (see conditions under Head of Household above) ..... **D** _____

E Enter the number of dependents you will claim on your tax return. **Do not** claim yourself or your spouse or dependents that your spouse has already claimed on their form K-4 ..... **E** _____

F **Add lines B through E** and enter the total here ..... **F** _____

K-4
(Rev. 7-24)

Kansas Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the Kansas Department of Revenue. Your employer may be required to send a copy of this form to the Department of Revenue.

1 Print your First Name and Middle Initial	Last Name	**2** Social Security Number

Mailing address	**3** Allowance Rate Mark the allowance rate selected in Line A above. ☐ Single ☐ Joint

4	Total number of allowances you are claiming (from Line F above)	**4**	
5	Enter any additional amount you want withheld from each paycheck (this is optional)	**5**	**$**
6	I claim exemption from withholding. (You must meet the conditions explained in the "Exemption from withholding" instructions above.) If you meet the conditions above, write "Exempt" on this line ..... **Note: The Kansas Department of Revenue will receive your federal W-2 forms for all years claimed *Exempt*.**	**6**	

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief it is true, correct, and complete.

SIGN HERE ▶ **Date**

7 Employer's Name and Address	**8** EIN (Employer ID Number)

Fiscal Management Services
504 Miller Drive PO Box 408 Wamego KS 66547
785- 456-8573 785-456-9915 TEXT Line: 844-617-9689

Direct Deposit Authorization Form

PAYROLL INSTRUCTIONS – Indicate below your choice to receive your paycheck biweekly on Fridays by direct deposit. Please double check your information to avoid payroll errors. Regardless of pay method; you will receive an email with a link to open your paystub when your pay is processed. Please provide the email you would like to use here:

Email:_____@_____

_____ I would like my wages deposited to my **CHECKING** account.

Bank Name * _____

Routing Number * _____ Account Number * _____

_____ I would like my wages deposited to my **SAVINGS** account.

Bank Name * _____

Routing Number * _____Account Number * _____

_____ I would like my wages deposited to a **PAYROLL CARD.**

_____ **WISELY PAY CARD** provided and mailed by Three Rivers.

_____ **PAY CARD** you provide:

Routing number * _____ Account number * _____

(For office use only)

Please make sure to include the ENTIRE routing and account number. A debit card will be issued if banking account information is not provided.

This authority is to remain in full effect until Employer or Financial Institution has received written notification from me fourteen (14) days prior to its termination, or until Employer or Financial Institution has sent me written notice of the Employer's or Financial Institution's termination of this agreement. It is my understanding that my paycheck will be deposited on payday, unless said day is not a banking day. I further acknowledge that in the event of mechanical or technological failure, or other circumstances beyond the control of the Employer or Financial Institution in connection with this service, I will accept my earned compensation in an alternative fashion customary with Employer's policies and procedures. In the event a transaction is rejected by the Receiving Depository Financial Institution due to the closing of an account or incorrect information given by me, I authorize the company to deduct from my compensation, the amount of any administrative fee charged by Employer's Financial Institution for the notification of said rejection. It is my understanding this enrollment is automatically cancelled upon the termination of my employment.

Employee Signature: _____ Date: _____

Print Name: _____Phone Number: _____

ck →

Attach voided check here.
(REQUIRED for a checking account.)

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Release of Information
Child Abuse and Neglect Central Registry

P.O. Box 2637 ● Topeka, KS 66601 ● FAX 785-296-1729 ●
DCF.CentralRegistry@ks.gov

This entire form must be completed before it will be processed. **All releases and fees are to be sent to the mailing address or email listed above with appropriate payment (see Payment/Account Information).**

***CONFIDENTIALITY**: Kansas Department for Children and Family records are confidential. No individual, association, partnership, corporation, or other entity shall willfully or knowingly disclose, permit, or encourage disclosure of the contents of records or reports in violation of the confidentiality requirements of K.S.A. 38-2209. Violation of this statute is a class A nonperson misdemeanor and the court may impose a civil penalty of up to $1,000.*

Contact Person: Cindy Agency/Org.: Three Rivers Inc Fiscal Agent

Phone #: 785-456-8573 Address: PO Box 408

Email: cynthiag@threeriversinc.org City/State/Zip: Wamego, KS 66547

Return Results by: ☒ Encrypted email (list if different than above): _____ ☐ Postal Mail

Payment/Account Information (check box which applies)

☐ *Fee included*	$10 per request. Check, Money Order (payable to DCF) or cash. ***Mail to address listed above.***	
☐ *Online Payment*	$10 per request. www.dcf.ks.gov >Online DCF Payments>Payment Portal. **Submit receipt with form(s)**	
☒ *Pre-Pay Account*	Agency/Org. has Pre-Pay Account.	**FEIN:** 32-0453490
☐ *Mentoring Account*	No fee for agencies listed in the Kansas Mentors' Partner Directory http://mentorkansas.org/Find-a-Program	
☐ *Exempt*	No fee for State government agencies (Sub-contracting agencies not included).	

1. I give permission for the release of any of my information in the Child Abuse/Neglect Central Registry to the contact listed above. I understand the information released is for their exclusive and confidential use: ☒ *Yes* ☐ *No*

2. This organization/person/agency may check my information each year I am employed or associated with them: ☒ *Yes* ☐ *No*

***APPLICANT**: **PRINT CLEARLY**. All requested information is required for processing. Incomplete or illegible information will result in processing delays for the Release of Information. Use 'N/A' rather than leaving a space blank.*

FIRST, MIDDLE, LAST NAME: _____

OTHER NAMES USED: (Any/all aliases, married, maiden, nicknames, etc. (Enter 'N/A' if none used):

_____

DATE OF BIRTH: _____ **RACE**: _____

SOCIAL SECURITY #: _____ **GENDER:** ☐ *Male* ☐ *Female*

CURRENT ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **EMAIL:** _____

SIGNATURE: _____ **DATE:** _____

Applicants under the age of 16 requires a parent/guardian signature and title of signatory.

For DCF use ONLY:

- A stamp in the Match box indicates the applicant is listed on the Central Registry.
- A stamp in the No Match box indicates the applicant is NOT listed on the Central Registry.

MATCH	NO MATCH

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

OBI 10400
REV 4/22

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Cindy **Phone** (785) 456-8573

Agency name Three Rivers, Inc.

Agency mailing address PO Box 408, Wamego, KS 66547-0408

Email address: Will return via Encrypted email unless marked otherwise cynthiag@threeriversinc.org

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☑ **Yes** ☐ **No**

Signature: _____ **Date**: _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations
Adult Abuse Registry
P.O. Box 751043
Topeka, Kansas 66675
(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	**For Official Use Only: Mark in this area if CLEARED**

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Cox, Kennetha Records Clerk		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Three Rivers Inc Fiscal Agent	504 Miller Dr PO Box 408, Wamego, KS 66547

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.