

CHS GROUP LLC.

EMPLOYMENT APPLICATION



Our company is an Equal Opportunity Employer (EOE). CHS Group LLC follows the policies in accordance to the EOE. The policy of this organization is not to discriminate on the basis of race, sex, religion, national origin, marital status, age, weight, height, color, or disability, in the hiring, promotion, payment, or discipline of employees.

If you are a person with a disability, you may request any needed reasonable accommodation to participate in the application process or interview process. This request should be made in advance so that we can make an accommodation. We do not discriminate against a person with a covered disability under the Americans with Disabilities Act in regard to employment practices, terms, conditions, and privileges of employment.

This application will be given every consideration, but its receipt does not imply that the applicant will be employed. Each question should be answered in a complete and accurate manner as no action be taken on this application until all questions have been answered.

NAME: DATE:

ADDRESS: CITY:

STATE: ZIP CODE: PHONE #:

EMAIL ADDRESS:

EMERGENCY CONTACT:

PHONE #:

Position(s) applied for: Desired start date: Salary desired:

Are you seeking: FULL TIME PART TIME TEMPORARY EMPLOYMENT?

Are there any days or hours you would be unable to work? YES NO

If yes, please specify the days or hours:

Have you received a job description for the position(s) for which you are applying? YES NO

If the position you applied for requires driving, do you currently have a valid driver's license? YES NO

Driver's License #:

Do you have any tickets on your driving record for moving violations? YES NO

If yes, state date(s) and violations:

Are you 18 years of age or older? YES NO Can you perform the duties of the job in which you wish to be employed, with or without reasonable accomodation? YES NO

Have you ever been convicted of a crime? YES NO If yes, was this crime a felony? YES NO
(NOTE: Affirmative answer to this question may not automatically preclude you from consideration of employment)

Are there any criminal charges pending against you? YES NO

If yes, please explain:

Are there any criminal charges pending against you? YES NO

If yes, please explain:

Do you have a professional license? (i.e. Nurse, Social Workers, etc?) YES NO

License #: State issued: Expires:

Has your professional license ever been suspended or revoked? YES NO

If yes, please explain:

Have you ever been involuntarily terminated? YES NO

If yes, please explain:

Have you ever been employed by this organization before? YES NO

If yes, give dates and facility employed at:

Do you know any employees of this organization? YES NO

If yes, list all names:

Are you related to any employees of this organization? YES NO

If yes, list relative's name:

If you worked in any of your previous positions under another name, please state that name:

Have you ever been administratively determined by a federal, state or local government agency to have committed abuse or neglect? YES NO

If yes, please explain where, when and nature of case:

NOTE: PLEASE SKIP PAGE 3 AND 4 IF RESUME WAS SUBMITTED WITH FOLLOWING INFORMATION:

List any special skills and/or training that would apply to this position and briefly state your reasons for wanting this position:

EDUCATION:

High School Attended:

City and State:

GRADUATE

GED

ADDITIONAL EDUCATION:

School and Address

Degree

Major

School and Address	Degree	Major
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

PERSONAL REFERENCES

Name

Relationship

Phone #

Name	Relationship	Phone #
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

WORK HISTORY:

Employer's Name:

Address:

City, State, Zip:

Dates of employment:

Starting pay:

Ending pay:

Title:

Duties:

Reason for leaving:

Employer's Name:

Address:

City, State, Zip:

Dates of employment:

Starting pay:

Ending pay:

Title:

Duties:

Reason for leaving:

WORK HISTORY (CONTINUED):

Employer's Name:

Address: City, State, Zip:

Dates of employment:

Starting pay: Ending pay:

Title: Duties:

Reason for leaving:

Employer's Name:

Address: City, State, Zip:

Dates of employment:

Starting pay: Ending pay:

Title: Duties:

Reason for leaving:

RELEASE OF INFORMATION

I hereby give CHS GROUP LLC my permission to contact the above employers, references and education institutions to verify the items I listed above are true. I hereby release CHS GROUP LLC, and the above referenced organizations, referenced persons and employers for all claims, liability and damages that may result from furnishing the information to you. I expressly and fully waive all written notice from all prior employers. I consent to releasing any information relating to my job performance, which is documented in my personal file.

I also understand that because of the nature of my job and licensing requirements, I hereby consent to the release of this application, or portions of this application, to representatives of the Department of Commerce, Department of Consumer and Industry Services, Family Independence Agency, Department of Community Health, and local Community Mental Health agencies, or other governmental or private agencies for all licensing or investigative purposes and to verify information I have listed in this job application. I hereby release CHS GROUP LLC., Department of Commerce, Department of Consumer and Industry Services, Family Independence Agency, Department of Community Health, and local Community Mental Health agencies, or other governmental or private agencies from all claims, liability, and damages that may result from furnishing the information to you.

I further specifically waive written notice and agree to the divulging of any disciplinary reports, letters of reprimand or other disciplinary action by all prior employers, and hereby release my prior employers from all claims, liability and damages that may result from furnishing the information to you.

Signature _____ **Date** _____

I further understand that any dishonest, false or incomplete answers on this application or in any subsequent interview are grounds for immediate dismissal.

Signature _____ **Date** _____

This application will be kept current for six months. You need to complete another application to be reconsidered after that date.

AFFIDAVIT

I certify that the answers given by me to the foregoing questions and statements are true and correct without any consequential omissions of any kind whatsoever. I understand that any misleading or incorrect statements may render this application void, and if employed, would be cause for my termination. I further agree that the company shall not be liable in any respect if my employment is terminated because of false statements, answers or omissions made by me on this form. I also authorize the employers, companies, schools or persons named above to give any information regarding my employment, character and qualification, including disciplinary reports, letters of reprimand and other disciplinary actions. I hereby release the employers, companies, schools or persons from all claims and damages that may result from furnishing this information. I understand Employment at Will, and if employed by CHS GROUP LLC., I will conform to the rules and regulations of CHS GROUP LLC., and that my employment and compensation can be terminated without cause and without notification at any time, at the sole discretion of CHS GROUP LLC. I agree that no one other than the President has any authority to enter into any agreement or contract for any specified period of time, or to make any agreement contrary to the foregoing. I also understand that no person is authorized to enter into any written or verbal employment contracts on behalf of the company without the express written consent of the President.

Signature _____ **Date** _____

COMPANY USE ONLY

Interviewed by: _____ **Date** _____

Interviewer's remarks: _____

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.

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)		

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: 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.

Multiple Jobs or Spouse Works 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 (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (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):		
	Multiply the number of qualifying children under age 17 by \$2,000	\$ _____	
	Multiply the number of other dependents by \$500	\$ _____	
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____

Step 4 (optional): 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. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

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)



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No. 1615-0047

Expires 05/31/2027

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.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien 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)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

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)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code		

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	OR	<ol style="list-style-type: none"> 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, sex, height, eye color, and address 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, sex, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • 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	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

DIRECT DEPOSIT AUTHORIZATION

DATA SERVICE CENTER, INC.

CLIENT NUMBER: _____

*This authorization form is used for the direct deposit of your payroll check. Employees requesting direct deposit must complete and sign the form, which the payroll department will keep on file. Employees need to **ATTACH A VOIDED CHECK** from their bank account to verify information on the authorization form. Notice that the form can be used to split deposits. You may want to have part of your pay deposited into your checking account and part deposited into your savings account, even at another bank.*

Employer Name: CHS GROUP SC

Location: _____

I hereby authorize my Employer to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error, to my account or accounts listed below.

Bank Name	Bank Routing Number	Bank Account Number	Checking - 1 Savings - 2	Flat Amount Deposited	-or- % of Paycheck Deposited
			TOTAL		

This authorization will remain in full force until the Employer has received written notification of its termination in such timely manner as to afford the Employer and the Financial Institution a reasonable opportunity to act on it. We will allow one change/termination per calendar quarter.

Employee Name: _____

Employee Clock Number: _____

Signature: _____

Date: _____

REQUEST FOR CENTRAL REGISTRY AND/OR CHILD ABUSE RECORD CHECK

Online Portal is available at: <https://providerportal@dss.sc.gov>

Utilize DSS Forms 2924 or 37201 for all Child Care Requests

I. Purpose for Request (check all that apply)

- A. I am requesting a search of the Central Registry of Child Abuse and Neglect **AND** the Department's database of records of Child Abuse and Neglect cases in connection with:
- Becoming or remaining a foster parent or potential adoptive parent
 - Adults over the age of 18 residing in a potential foster home or adoptive home
 - Becoming an employee or volunteer for Richland County CASA
 - Becoming an employee or volunteer for the S.C. Department of Children's Advocacy to include: Continuum of Care; Foster Care Review Board and/or SC Guardian ad Litem Program
 - Group Home (emergency shelters, wilderness camps, Child Caring Institution)
- B. I am requesting a search of the Central Registry of Child Abuse and Neglect **ONLY** in connection with:
- Becoming or remaining an employee or volunteer for Adult Care
 - Other: Please specify _____

II. Please check appropriate fee box and include payment (Check or Money Order ONLY) Only one category applies!

- | | | | |
|--|----------|---|---------|
| <input type="checkbox"/> Non -Profit Entities (CASA, etc.) | \$ 8.00 | <input type="checkbox"/> Name Change | \$ 8.00 |
| <input type="checkbox"/> For Profit Entities | \$ 25.00 | <input type="checkbox"/> Foster Care/Adoption | \$ 8.00 |
| <input type="checkbox"/> State Agencies | \$ 8.00 | <input type="checkbox"/> Private Adoptions Investigations | \$25.00 |
| <input type="checkbox"/> Schools | \$ 8.00 | <input type="checkbox"/> Adult Care Facility | \$ 8.00 |
| <input type="checkbox"/> Group Home Facilities | \$ 25.00 | <input type="checkbox"/> Other (individual request, etc.) | \$ 8.00 |

III. Please print or type the entire name of person to be searched. Incomplete or illegible forms will not be processed.

Full Name (No Initials): _____ DOB: _____ Gender: _____ Race: _____
First Middle Last

Maiden/Former Name/Aliases: _____ Complete SSN (No X's): _____

Place of Birth: _____

Current Address: _____ Previous Address(es): _____

IV. Mail Results to:

Name: _____ ATTN: _____

Address: _____ Tel. No. _____

City/State/Zip: _____ Email: _____

V. I do hereby authorize the South Carolina Department of Social Services (SCDSS) to research its records to determine whether they contain information that I was the perpetrator of harm to a child and to release information found to the individual/organization named above. I understand that the information provided may prove to be unfavorable to me. I agree to hold SCDSS and its staff harmless from liability associated with the release of information requested on this form. If it appears to me that the information has not been updated or is otherwise inaccurate, I agree to notify the Department immediately.

Please mail appropriate payment (check or money order only) payable to: **Department of Social Services (DSS)** and form for processing to: South Carolina Dept. of Social Services, **ATTN: Cashier**, 1535 Confederate Avenue, PO Box 1520, Columbia, SC 29202-1520.

Your signature **MUST** be witnessed or notarized.

Signature of Applicant

Date

Signature of Witness

Date

VI. Results: THIS SECTION IS TO BE COMPLETED ONLY BY AUTHORIZED DSS EMPLOYEES OF THE DEPARTMENT.

- The name is not included as a perpetrator on the Central Registry of Child Abuse and Neglect.
- The request has been received. Additional research will be required to respond to the request. Thirty to Sixty days may be required. Please call _____ if you have any questions.
- The name is included as a perpetrator on the Central Registry of Child Abuse and Neglect.**
- The name is included as a perpetrator in the Department's database of records of child abuse and neglect cases. See attached correspondence

Authorized DSS Employee

Date

INSTRUCTIONS FOR DSS FORM 3072 – CONSENT TO RELEASE INFORMATION

PLEASE DO NOT ALTER THIS FORM IN ANY WAY

SECTION I: Purpose for Request: To provide authorization for the SC Department of Social Services to conduct a search of the State Central Registry of Child Abuse and Neglect and/or the DSS Database and to release results. Please indicate the purpose of the search by checking in the appropriate box.

SECTION II: Central Registry Fee: Please check appropriate fee box.

SECTION III: Please type or print legibly the following information:

- Full Name: Provide complete spelling of name to include the first, middle and last name - **NO INITIALS.**
- Maiden/Former Name/Aliases: List the name(s).
- Date of Birth: Month/Day/Year
- Gender: (Self Explanatory)
- Race: (Self Explanatory)
- Social Security Number: All the information requested on this form is necessary to conduct a thorough search. Your SSN will be used **only** to conduct what we hope will be a thorough central registry/database check and will not be given to any person other than indicated agency or entity.
- Place of Birth: Provide the name of the State you were born in.
- Current Address: Provide your current residence.
- Previous Address: If current address is less than 7 years; list other addresses, States, Countries you have resided in for the past seven years. Use separate sheet if necessary.

SECTION IV: Mail Results To: Please ensure that you type or stamp the return address next to, "MAIL RESULTS TO," on this form. Please include the contact person's name, telephone number, and email.

SECTION V: Mail payment payable to Department of Social Services (DSS); completed Form 3072 Consent to Release Information, and a stamped addressed envelope to:

**South Carolina Department of Social Services
Attention: CASHIER
1535 Confederate Avenue
P.O. Box 1520
Columbia, SC 29202-1520**

- Signature of Applicant: Requesting the applicant's original signature for a one-time search of the State Central Registry of Child Abuse and Neglect and/or the DSS Database and to release results.
- Signature of Witness or Notary: The applicant's signature must be witnessed or notarized prior to submitting for processing.

PLEASE CALL (803) 898-7318 EXTENSION 4, IF YOU NEED ASSISTANCE COMPLETING THIS FORM.

After receipt by cashier and processing of payment, the Central Registry/DATABASE check will be completed by authorized DSS personnel in the Division of Child Welfare Services.

DSS personnel in the Division of Child Welfare Services must do the following:

1. Conduct Central Registry check and/or Database search in accordance with Section I. A or B.
2. Check appropriate results box.
3. Sign and date form; Results are returned via online portal or envelope is stamp, "confidential" and mail to return address.

Distribution

Results of the search will be sent **ONLY** to the individual or organization specified in Section IV of this form.



South Carolina Criminal Check Authorization

- I authorize CHS Group LLC (potential employer) to verify information presented to them on my application in Section 391.23 of the Federal Motor Carrier Safety Regulations and the disclosure requirements under the Fair Credit Reporting Act, with regard to my prospective employment with CHS Group LLC. I hereby release CHS Group LLC, the Federal Bureau of Investigation (FBI) of South Carolina State Law Enforcement Division (SLED) and their assignors or successors from all liability or claims and authorize the FBI or SLED to release to CHS Group LLC my criminal history information.
- I understand that each incident documented in the criminal background report may result in decision not to hire or to terminate employment. Generally felonies or higher crime will result in a negative discrimination for employment.
- New employment will be temporary until CHS Group LLC has secured a valid criminal check. If at the time on receiving this check, unacceptable criminal incidents are recorded, separation from employment will be immediate.
- In accordance with the provision of Sections 604 and 607 of the Fair Credit Reporting Act PL 91-508, CHS Group LLC hereby certifies that the information requested will be used for permissible purposes only as defined in the Act and that the information received will be used for no other purpose.
- The CHS Group LLC certifies that if the applicant is denied employment based on the information received, they will identify the source of the report in accordance with Section 615 (a) of the Fair Credit Reporting Act.

Proof of Insurance

- CHS Group LLC requires employees to obtain a copy of current “proof of insurance” within 3 business days. Failure to do so will result in termination or suspension of employment.

Driving Record Authorization

- CHS Group LLC requires a VALID LICENSE for employment. Staff will be put on an indefinite leave of absence or the following: If at any time after employment begins, a staff’s driving status changes (suspended license - multiple moving violations) therefore unable to perform job duties and the company insurance will not cover staff.
- Once the staff has the proof of a valid license, a driving record will be completed by the South Carolina Department of Motor Vehicles (SCDMV) and consideration for continued employment will be made by the Program Manager.



If employee **does not have a South Carolina** driver’s license, employee is responsible for obtaining driving record of the state in which they reside in. CHS Group LLC will reimburse the cost to employee upon receipt of the documents.

I hereby authorize CHS Group LLC to run a criminal history/background check as well as a driving record check to be completed by the DMV, SLED or FBI.

EMPLOYEE NAME: _____ **SIGNATURE:** _____

DATE: _____



MISSION STATEMENT

Maximize potential through personal commitment, collective talents and innovations. CHS supports individuals with diverse challenges in shaping distinctive, meaningful lives.

VALUES

Take a lot of PASSION for helping people.
Mix that with an ATTITUDE of hard work.
Get your LISTENING skills ready.
Make the COMMITMENT to help others.

TO ACHIEVE INDEPENDENCE

TEACH
ASSIST
PROMPT

EMPLOYEE NAME: _____ SIGNATURE: _____

DATE: _____

Performance Standards

- Speak to all people politely, as you would like to be spoken to
- Include all people in conversations; speak with them, not about them
- Use positive verbal and non-verbal communication; avoid being negative Explain things in ways that people can understand and observe how they receive the information
- Encourage people to think by asking questions rather than giving commands
- Teach individuals to do as much as possible for themselves rather than doing for them
- Include people in making decisions by providing choices; fry not to be bossy
- Respect differences and an individual's desires, needs and values
- Consider seriously the feelings and concerns of others even if they don't seem important to you
- Listen to each other's point of view, even if upset or involved in a disagreement, and not allow it to affect your behavior

Code of Ethics

Person-centered support:

As a CHS employee, my first allegiance is to the person support; all other activities and functions I perform flow from this allegiance.

Promoting physical and emotional well-being:

As a CHS employee, I am responsible for supporting the emotional, physical and personal well-being of the individual, receiving support while being attentive and energetic in reducing their risk of harm.

Integrity and responsibility:

As a CHS employee, I will support the mission and vitality of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals and the community.

Confidentiality:

As a CHS employee, I will safeguard and respect the confidentiality and privacy of the people I support.

Justice, fairness and equality:

As a CHS employee I will promote and practice justice) fairness and equality for the people I support and the community. I will affirm the human and civil rights and responsibility of the people I support.

Respect:

As a CHS employee, I will respect the human dignity and uniqueness of the people I support, I will recognize each person I support as valuable and help others understand their value.

EMPLOYEE NAME: _____ **SIGNATURE:** _____

DATE: _____



CONFIDENTIALITY

Consumers:

Each consumer has the right to confidentiality; by accepting employment with CHS you are placed in a position of trust regarding information about the consumers of this program, each employee must constantly be aware of the confidential nature of all information pertaining to the consumers.

All information in the record of a consumer and/or acquired in the courses of providing services to a consumer shall not be open for public discussion.

Consumer information may be disclosed to the agency or organization which oversees services for the consumer, or to the agency or organization or individuals assigned as guardian for the consumer, or to the new agency or organization that is providing services to the consumer, i.e. in the event of a consumer is transferred to another agency or organization. Guardian's permission must be on record before information may be disclosed. Any discussion regarding consumers outside the home should be for professional reasons only. The identity of the person must be protected. Both first and last names should never be used together, nor should a description of the individual be given.

Failure to comply with consumer confidentiality requirements will result in disciplinary action and may result in a recipient rights violation by local and state regulations.

Employee:

Any employee who, during his or her daily duties, has access to or encounter current or previous employee information, i.e. addresses, phone numbers, wage rates increase prohibited from disseminating it to anyone in any manner without the approval of the employer.

Individual personnel files are the property of the company and are considered confidential between the employee and supervisor staff or specific designee, failure to comply constitutes a breach of confidentiality and may result in disciplinary action.

Media:

CHS employees are not authorized to release information to news reporters or other media representatives, except at the direction and approval of the president of the company, if a contact is made, the employee should request the name and phone number of the representative and inform him or her to contact the president.

EMPLOYEE NAME: _____ **SIGNATURE:** _____

DATE: _____

FEDERAL FALSE CLAIMS ACT
THE ORIGIN OF PREVENTING FRAUD

**I have read and understood the Power Point concerning
the Federal False Claims Act!!!**

EMPLOYEE NAME: _____ DATE: _____

EMPLOYEE SIGNATURE: _____

SUPERVISOR SIGNATURE: _____



Hepatitis B Vaccination Acceptance/Waiver

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk acquiring Hepatitis B virus (HBV) infection. I know the use of “universal precautions” when working is necessary for the control of infectious diseases but “universal precautions” will not necessarily protect me from contracting Hepatitis B.

- I choose to HAVE the Hepatitis Vaccine
- I choose NOT to have the Hepatitis Vaccine

I understand that the immunization regimen consists of three (3) doses of vaccine given according to the following schedule:

1st dose	at elected date
2nd dose	one month later
3rd dose	six months after 1st dose



If I choose not to have the vaccination, I release CHS Group from any liability, real or implied, should I contract Hepatitis B during the course of my employment with CHS Group. I understand that any injury I may suffer during the course of my employment with CHS, that results in my contracting Hepatitis B, may not be eligible for paid benefits or disability through workers’ compensation insurance. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

EMPLOYEE SIGNATURE: _____ **DATE:** _____



RECORD OF VACCINE

Date of 1st dose _____

Date of 2nd dose _____

Date of 3rd dose _____

STATEMENT OF AGREEMENT

I hereby confirm that I have received, read and understand the policies and guidelines detailed within the CHS Group Employee Handbook effective July 1st, 2018.

I understand that my employment is at-will and may be terminated by CHS Group or me at anytime with or without notice and with or without cause.

I also understand that the management of CHS Group reserves the right to revise any part or all of the policies and materials in this handbook by addition, reduction, correction, deletion or updating, and may provide notice when such changes will be implemented.

Limitation of Actions

BY ACCEPTING AND CONTINUING EMPLOYMENT WITH CHS, EACH EMPLOYEE AGREES NOT TO COMMENCE ANY CLAIM, COMPLAINT, ACTION OR SUIT RELATING TO HIS/HER EMPLOYMENT WITH CHS OR ITS PROFESSIONAL STAFF MANAGEMENT PROVIDER MORE THAN ONE HUNDRED EIGHT (180) CALENDAR DAYS AFTER THE EVENT GIVING RISE TO THE CLAIM, COMPLAINT, ACTION, OR SUIT OR LATER THAN THE APPLICABLE LIMITATIONS PERIOD ESTABLISHED BY STATUTE, WHICHEVER IS LESS. FURTHER ANY WRONGFUL EMPLOYMENT PRACTICE, CLAIM IS SUBJECT TO THE ARBITRATION AGREEMENT SIGNED BY YOU UPON EMPLOYMENT.

EMPLOYEE NAME: _____ **DATE:** _____

EMPLOYEE SIGNATURE: _____

REFERENCE CHECK CONTROL FORM

Applicant Name: _____ **Position:** _____

Personal References Checked

Reference One

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Date Contacted: _____ Method of contact: _____

Notes: _____

Reference Two

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Date Contacted: _____ Method of contact: _____

Notes: _____

Reference Three

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Date Contacted: _____ Method of contact: _____

Notes: _____

Employment References Checked

Reference One

Name: _____ Relationship: _____

Company/Organization: _____ Telephone: _____

Date Contacted: _____ Method of contact: _____

Notes: _____