Missouri
Credentialing Board

(573) 616-2300 www.missouricb.com email: help@missouricb.com 428 E. Capitol, 2nd Floor Jefferson City, MO 65101

Grandfathering (GF) Criteria for Community Health Worker (CHW)

I. Criteria

- Minimum of HS Diploma/HSE
- Completion of DHSS approved CHW Standard Training Program **OR**
- 800 hours of CHW experience within the last 3 years of applying

CHECK LIST FOR CHW GF APPLICATION

1. You have submitted a $50.00 check with this application or have provided your credit/debit card information on page 4 of this application packet. **Applications will not be reviewed until payment is received.**
2. You have completely filled out the application.
3. You have signed the Code of Ethics.
4. You have filled out the Family Care Safety Registry Worker Registration Form and included the form with your packet. If your agency has conducted a FCSR background check on you within the last 30 days, you may submit the results to help expedite the application process.
5. The appropriate documentation was sent to verify the required educational/training program or the 800 hours of work experience.
6. The appropriate High School/HSE or College transcripts were sent.

10 Typically, applications are reviewed within two weeks of receipt in the MCB office. If you have not received written or e-mail correspondence from the MCB 3 weeks after mailing your application to the MCB, call the MCB.

11 Check the Professional Search on the MCB web site homepage at www.missouricb.com. Type in your last name. If your application is complete, your credential information will be displayed and your certificates will be mailed soon.

Missouri
Credentialing Board

(573) 616-2300 www.missouricb.com email: help@missouricb.com 428 E. Capitol, 2nd Floor Jefferson City, MO 65101

Application Instructions:

1. Requirements to receive this credential are subject to change without notice. Please make sure you are submitting the most recent application packet. If you are unsure, contact the MCB office.
2. The application must be typed or **neatly printed.**
3. Please keep a copy of all materials submitted for your records.
4. FEES: The total CHW GF Fee is $50.00. You may pay by check, money order, or provide credit card information on page 4 of this application packet. **Applications will not be reviewed until payment is received.**
5. Please be aware that should your application be reviewed and additional information is requested to complete the application, you will have 90 days to provide the requested information. Failure to do so will result in your application expiring without being approved.
6. All fees are non-refundable. If your application is denied or expires, fees will not be refunded.
7. If your application is denied, you may contact the MCB office staff for instructions on how to appeal the denial of your application.
8. All materials submitted to the MCB office become property of the MCB.
9. The applicant must currently reside and/or work/volunteer in the State of Missouri at least 51% of the time. The only exception to this is applicants living and working in a state that is not a member of the International Certification and Reciprocity Consortium.
10. If at any time during the credentialing process, a question arises about an applicant's moral character, reputation for honesty, integrity, or professionalism, the Board may either deny the application at that time or place the application on hold until an investigation has been completed and a decision made regarding the question brought up.
11. Please remember that it is your responsibility to keep the MCB office informed of any personal informational changes such as address and phone number changes. If you fail to notify us of changes, you will be responsible for any material that is mailed to the wrong address and will have to pay a fee to have the material sent again.
12. **Please <u>mail</u> your application to the MCB. Please do <u>not</u> fax or e-mail your application.**

Important Notice To Applicants

According to Missouri Credentialing Board (MCB) Policies and Procedures, the following rules apply to those seeking a MCB credential.

1. The following items disqualify an individual from obtaining the CHW with the MCB:
   A. Is listed on the Department of Mental Health disqualification registry
   B. Is listed on the employee disqualification list of the Dept. Health and Senior Services or Dept. of Social Services
   C. Any crime against a minor
   D. A person who has been convicted of, found guilty to, plead guilty to or nolo contendere to any of the Disqualifying Crime (s) Pursuant to Section 630.170, RSMo. The crime (s) will only disqualify an applicant if the crime (s) were a felony. Please view information about Section 630.170, RSMo on the MCB web site www.missouricb.com under the Disqualifying Crimes Link.
2. If an individual has applied for and been given an exception from the CHW Association, the individual may apply for a MCB credential. Please send in proof of exception with your application.
3. If an individual was denied an exception from the CHW Association and would still like to be credentialed, the individual may apply directly to the Missouri Credentialing Board exceptions committee.

GRANDFATHERING APPLICATION

FOR

Community Health Worker (CHW)

Appropriate fee must be submitted with application.

MISSOURI CREDENTIALING BOARD
428 E. Capitol, 2nd Floor
JEFFERSON CITY, MISSOURI 65101

TELEPHONE: (573) 616-2300

WEB SITE: www.missouricb.com

EMAIL: help@missouricb.com

Please Mark Credit Card Type:

1. Visa _____
2. MC _____
3. Discover _____

CC Expiration Date: _____/_____

Credit Card #: _____-_____-_____-_____

Credit Card 3 Digit Verification Code: _____

THIS APPLICATION MUST BE TYPED OR PRINTED NEATLY

All Applications Become the Property of MCB

Applicant's Name: _____
First Middle Last Name Suffix (Jr., II)

_____
Maiden Other Names Used

Current Home Address: _____
Street/PO Box Apt. #

_____
City State Zip County

Home Telephone: _____/_____ SSN: _____-_____-_____

Work Telephone: _____/_____, Ext. _____ Cell Number: _____/_____

E-mail Address: _____

SEX: ☐ M ☐ F BIRTH DATE: ____/____/_____

Are you currently or have you been credentialed or licensed by the MCB or any other state or organization? ☐ Yes ☐ No

If yes, which state/organization and when? _____

What is the type of credential/license held with the other state/organization?

_____

Have you ever been **ARRESTED** and/or **CONVICTED** of a felony? ☐ Yes ☐ No

If yes, please go to the www.missouricb.com website, print off the "Felony Offense Form", fill out the form and submit with your application. If you were convicted of a felony listed in Section 630.170 RSMo (view www.missouricb.com; Disqualifying Crimes link), you may not apply for this credential without an exception from the CHW Association or the MCB Exceptions Committee. **(If you have already completed the Exceptions Process, you do not need to complete the Felony Offense Form)**

Have you ever knowingly been contacted by a Children's Division employee regarding a **CHILD ABUSE** and/or **CHILD NEGLECT** incident involving you? ☐ Yes ☐ No

If yes, please go to the www.missouricb.com website, print off the "Child Abuse/Neglect Statement", fill out the form and submit with your application. In addition, please contact the Children's Division at 573-751-4920 and request a report of the incident to include with this application.

Education/Degree Information

Please mark your highest level of education completed:

1. High School Diploma/HSE: _____
2. Addiction Certificate Program: _____
3. Associate Degree: _____ Degree Program: _____
4. Bachelor Degree: _____ Degree Program: _____
5. Master Degree/Higher: _____ Degree Program: _____

An applicant may document High School Diploma or HSE or College/University degree by:

1. Submitting copy of High School Diploma/HSE
2. Submitting official or unofficial College/University transcripts. Please ensure the transcript shows the applicable degree being conferred.

Where Does the Applicant Currently Work?

Name of Employer:					
Mailing Address of Employer	Street	City	State	Zip Code	County
Name & Title of Immediate Supervisor:					
Your Business Phone: Area Code/Telephone Number		Extension	Fax #	Area Code/Telephone Number	

Training Requirements

A. Submit documentation of the completed required DHSS approved CHW training program **OR**
B. Documentation of 800 work experience hours obtained within the last 3 years which should be documented on the Work/Volunteer page of this application.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ONE BOX ONLY)

☐ CHILD CARE WORKER ($9.☐) ☐ PERSONAL CARE WORKER ($9.00) ☐ XX VOLUNTARY REGISTRANT

☐ ELDER CARE WORKER ($9.☐) RECIPIENT OF STATE OR FEDERAL FUNDS (☐☐0) FOSTER PARENT (NO FEE)

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

LAST NAME	FIRST NAME	MIDDLE NAME

MAIDEN AND PRIOR NAMES USED

SOCIAL SECURITY NUMBER *(ATTACH COPY OF SOCIAL SECURITY CARD)*	DATE OF BIRTH	GENDER	TELEPHONE NO. (OPTIONAL)
- -	/ /	☐ MALE ☐ FEMALE	( )

MAILING ADDRESS

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY

HOME ADDRESS (if different than mailing address)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

EMPLOYER NAME	CONTACT PERSON	PHONE NUMBER
		( )

ADDRESS	CITY	STATE	ZIP CODE

SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

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. Futhermore, I authorized the Missouri Department of Health and Senior Services 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 subdivision (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 in the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening determination.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to your designated bank account. I understand that my signature below authorized my Financial Institution to deduct this payment from my account. In the event that DHSS or its subcontractor, is unable to secure funds from your account or you provide insufficient or inaccurate information regarding your account, your 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 (REQUIRED IN INK)	DATE
▶	/ /

Submit this form with your application and a copy of your SS card. If your agency has ran a FCSR check within the last 30 days, you can submit the results with this form which may speed up the application process. By doing so, you give permission for your agency to share their FCSR results.

Applicant's Agreement to the Code of Ethical Practice and Professional Conduct

I have read the current Community Health Worker's Ethics Code as listed on the MCB web site www.missouricb.com, MCB Ethics Code Link and agree to abide by this code:

Print Name Date

Signature Date

AUTHORIZATION AND RELEASE

I hereby certify all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any relevant investigations, or the release of personal information to the Missouri Credentialing Board, its agents, or contractors pursuant to this application/renewal procedure. I understand falsification of any portion of this application/renewal will result in my being denied credentialing, or revocation of same upon discovery.

I further agree to hold the Missouri Credentialing Board and its Board Members, officers, agents, staff, peer evaluators and examiners, free from any civil liability for damages or complaints by reason of any action that is within the scope and arise out of the performance of their duties which they, or any of them, may take in connection with this application/renewal, any examination, the grades with respect to any examination, and/or the failure of the MCB to issue me said credential or renewal.

This Authorization and Release shall also apply to personal information requested by the Board at any time following credentialing in connection with any investigation concerning allegations that could lead to disciplinary action against me.

Print Name Date

Signature Date

Missouri Credentialing Board

428 E. Capitol, 2nd Floor, Jefferson City, MO 65101

WORK/VOLUNTEER VERIFICATION FORM

An applicant is applying to the MCB for a Community Health Worker Credential. Please complete this form and provide a copy to the applicant to include with their application.

Applicant's Name: _____

Supervisor's Name (Print):_____

Organization Name: _____

Address: _____

_____

Telephone: _____

E-mail: _____

Today's Date: _____

Within the last 3 years from the date listed above, please list the **composite total** number of hours the applicant spent working with clients in the role of a Community Health Worker. This work can be paid work or volunteer work:

Community Health Worker: _____

Supervisor's Name (Printed): _____

Supervisor's Signature: _____

Date: _____