

LINK ASSOCIATES

1452 29th Street
West Des Moines, Iowa 50322
515-262-8888

Dear Applicant:

Enclosed is everything needed to complete your application for employment at Link Associates. We are anxious to meet with you and share the vast opportunities our agency has to offer. To process your application, the following must be completed and/or occur:

1. The highlighted areas on EACH form must be completed and signed.
Incomplete or unsigned applications will NOT be considered
2. Employment at Link Associates is contingent upon:
 - a. Link receiving two (2) acceptable references from former employers (please fill out all three)
 - b. An acceptable background check including abuse and criminal records
 - c. An acceptable driving record
3. Please be specific on the forms as to the day(s) and times you are available or interested in working. This will help us assure you interview with the appropriate supervisor.

We thank you for considering Link Associates and we will be happy to answer any questions you may have. Please call 262-8888 with any questions.



LINK

ASSOCIATES

1452 29th West Des Moines, IA 50322
 (515) 262-8888 – phone #
 (515) 262-8655 - fax #

DATE: _____

APPLICATION # _____

NAME: _____
 Last Name First Name Middle Initial

ADDRESS: _____
 Street City State Zip

TELEPHONE: () _____ SOCIAL SECURITY #: _____

CELL PHONE: () _____ E-MAIL ADDRESS: _____

POSITION(S) APPLIED FOR: _____

HOURS AVAILABLE: Full Time _____ Part Time _____
 Overnight _____ Weekend _____ Day _____ Evening _____

When would you be available to start? _____

Do you have the following (check the boxes for all you have)
 CPR First Aid Mandatory Reporter Computer Skills Medication Manager Sign Language Other _____

TYPE OF SCHOOL	NAME OF SCHOOL	CIRCLE HIGHEST GRADE/YEAR COMPLETED				GRADUATED		TYPE OF DIPLOMA OR DEGREE	MAJOR
		9	10	11	12	NO	YES		
HIGH SCHOOL									
COLLEGE/ UNIVERSITY		1st	2nd	3rd	4th				
GRADUATE SCHOOL		1st	2nd	3rd	4th				
OTHER MILITARY – VOCATIONAL									

	Yes	No
1. Have you ever applied with Link before? If yes, when?		
2. Have you been employed by Link before? If so, when?		
3. Are you legally permitted to work in the United States?		
4. Are you less than 18 years old?		
5. Have you been known by another name? If yes, list.		
6. Do you have reliable transportation?		
7. Do you have a valid Driver's license?		
8. If your position requires use of your vehicle, do you have proof of current insurance?		
9. Have you ever been convicted of a crime, other than minor traffic violation in this state or any other? If yes, explain.		
10. Do you have a record of founded dependent adult or child abuse in this state or any other?		
11. May we contact your present employer?		
12. May we contact your past employer (s)?		
13. How were you referred to us? Please circle response. Newspaper (list name of paper) Link Employee (list name) Workforce Dev. Other-Please list		

** an equal opportunity employer*

List Employment & Business Experience (include Volunteer, Intern, summer or Prior U.S. Military Service)

Current Employer	Phone #
Address	Supervisor
Dates: From _____ To _____ (month & year) (month & year)	(wage/salary) beginning _____ end _____
Duties:	Reason for leaving
Previous Employer	Phone #
Address	Supervisor
Dates: From _____ To _____ (month & year) (month & year)	(wage/salary) beginning _____ end _____
Duties:	Reason for leaving
Previous Employer	Phone #
Address	Supervisor
Dates: From _____ To _____ (month & year) (month & year)	(wage/salary) beginning _____ end _____
Duties:	Reason for leaving
Previous Employer	Phone #
Address	Supervisor
Dates: From _____ To _____ (month & year) (month & year)	(wage/salary) beginning _____ end _____
Duties:	Reason for leaving

Please read the following statements carefully. Sign only after the entire application has been completed.

1. **The information I have provided on this application is accurate to the best of my knowledge and subject to validation by Link Associates. I am aware that any deliberate falsification constitutes grounds for rejection of my application or dismissal if I am hired.**
2. I understand that employees of Link Associates are employed in an at-will status. Either the employee or the employer may terminate employment at any time for any reason.
3. I understand that consideration for employment is conditioned upon the positive results of reference checks, and the successful completion of a company health screening.
4. **I understand that driving records, criminal records, dependent adult abuse records, and child abuse record checks may be performed on me and that if they are unfavorable it constitutes grounds for rejection of my application or dismissal if I am hired.**
5. I understand that if employed, I will be required to abide by all employer policies, procedures and regulations.
6. **I have read the job description for which I am applying and am able to complete the essential functions of the job. Should I need modifications, I will request them at this time.**

Signature of Applicant _____ Date of Signature _____

Thank you for completing this application. You can be assured that our review of your job qualification will be based solely on merit and a final determination reached as quickly as possible.

LINK ASSOCIATES
EMPLOYMENT REFERENCE CHECK (#1)

1452 29th St. West Des Moines, IA 50322 • (515) 262-8888 Fax (515) 262-8655

Applicant # _____

CONSENT TO RELEASE INFORMATION
(TO BE COMPLETED BY THE APPLICANT)

I hereby authorize my present and former supervisor or employer to disclose to Link Associates any and all information with respect to my present or former employment for the purpose of pre-employment consideration. A photocopy of this authorization shall be considered as an effective and valid use of the original.

I authorize all references, professional and personal; to release the information requested to Link Associates.

SIGNATURE: _____ DATE: _____

Please Print Your Name Social Security Number

Employer Supervisor's Name

Street Address Phone Number

City, State, Zip Fax Number

TO BE FILLED OUT BY EMPLOYER/SUPERVISOR:

How do you know this applicant? _____

Dates of Employment: From _____ To _____

Applicants job title and duties: _____

Would you re-hire this applicant? Yes _____ No _____

Reason for leaving: _____

Attendance/Punctuality: Excellent _____ Good _____ Poor _____

Works well with minimum supervision? Excellent _____ Good _____ Poor _____

Work performance: Excellent _____ Good _____ Poor _____

Would hire this applicant to baby-sit your own children? Yes _____ No _____

Strong points: _____

Areas for improvement: _____

Additional Comments: _____

PRINT NAME (Reference checked by)

TITLE

SIGNATURE

DATE

EMPLOYMENT REFERENCE CHECK (#2)

1452 29th St West Des Moines, IA 50322 • (515) 262-8888 Fax (515) 262-8655

Applicant # _____

CONSENT TO RELEASE INFORMATION

(TO BE COMPLETED BY THE APPLICANT)

I hereby authorize my present and former supervisor or employer to disclose to Link Associates any and all information with respect to my present or former employment for the purpose of pre-employment consideration. A photocopy of this authorization shall be considered as an effective and valid use of the original.

I authorize all references, professional and personal; to release the information requested to Link Associates.

SIGNATURE: _____ DATE: _____

Please Print Your Name Social Security Number

Employer Supervisor's Name

Street Address Phone Number

City, State, Zip Fax Number

TO BE FILLED OUT BY EMPLOYER/SUPERVISOR:

How do you know this applicant? _____

Dates of Employment: From _____ To _____

Applicants job title and duties: _____

Would you re-hire this applicant? Yes _____ No _____

Reason for leaving: _____

Attendance/Punctuality: Excellent _____ Good _____ Poor _____

Works well with minimum supervision? Excellent _____ Good _____ Poor _____

Work performance: Excellent _____ Good _____ Poor _____

Would hire this applicant to baby-sit your own children? Yes _____ No _____

Strong points: _____

Areas for improvement: _____

Additional Comments: _____

PRINT NAME (Reference checked by)

TITLE

SIGNATURE

DATE

**LINK ASSOCIATES
EMPLOYMENT REFERENCE CHECK (#3)**

Applicant # _____

CONSENT TO RELEASE INFORMATION
(TO BE COMPLETED BY THE APPLICANT)

I hereby authorize my present and former supervisor or employer to disclose to Link Associates any and all information with respect to my present or former employment for the purpose of pre-employment consideration. A photocopy of this authorization shall be considered as an effective and valid use of the original.

I authorize all references, professional and personal; to release the information requested to Link Associates.

SIGNATURE: _____ DATE: _____

Please Print Your Name Social Security Number

Employer Supervisor's Name

Street Address Phone Number

City, State, Zip Fax Number

TO BE FILLED OUT BY EMPLOYER/SUPERVISOR:

How do you know this applicant? _____

Dates of Employment: From _____ To _____

Applicants job title and duties: _____

Would you re-hire this applicant? Yes _____ No _____

Reason for leaving: _____

Attendance/Punctuality: Excellent _____ Good _____ Poor _____

Works well with minimum supervision? Excellent _____ Good _____ Poor _____

Work performance: Excellent _____ Good _____ Poor _____

Would hire this applicant to baby-sit your own children? Yes _____ No _____

Strong points: _____

Areas for improvement: _____

Additional Comments: _____

PRINT NAME (*Reference checked by*)

TITLE

SIGNATURE

DATE

To request information about dependent adult abuse, complete this form and mail it to:

Central Abuse Registry, Iowa Department of Human Services, 1305 E. Walnut, Des Moines, Iowa 50319-0114

Note: Information will be released only to people who have access to it under Iowa Code section 235B.6

Criminal Penalties (235B.12)

1. Any person who willfully requests, or seeks to obtain dependent adult abuse information under false pretenses, or who willfully communicates or seeks to communicate dependent adult abuse information to any agency or person except in accordance with section 235B.6 and 235B.8, or any persons connected with any research authorized pursuant to section 235B.6 who willfully falsifies dependent adult abuse information or any records relating thereto, is guilty of a serious misdemeanor. Any person who knowingly, but without criminal purposes, communicates or seeks to communicate dependent adult abuse information except in accordance with section 235B.6 and 235B.8 shall be guilty of a simple misdemeanor.
2. Any responsible grounds for belief that a person has violated any provision of this chapter shall be grounds for the immediate withdrawal of any authorized access such person might otherwise have to dependent adult abuse information.

Redissemination of Dependent Adult Abuse Information (235B.8)

1. A recipient of dependent adult abuse information authorized to receive the information shall not redisseminate the information, except that redissemination shall be permitted when all of the following conditions apply:
 - a. The redissemination is for official purposes in connection with prescribed duties or, in the case of a health practitioner, pursuant to professional responsibilities.
 - b. The person to whom such information would be redisseminated would have independent access to the same information under section 235b.6
 - c. A written record is made of redissemination, including the name of the recipient and the date and purpose of the redissemination.
 - d. The written record is forwarded to the registry within thirty days of the redissemination.

Name of the person making request:		Office phone:	
Office address:			
Position and basis for authorization (Code 235B.6):			
Information requested concerning (name – first, middle, last):		Social security number:	Birth date:
Maiden name or alias (if applicable):	Address:		
What information is requested:			
Date	Signature		
To be completed by Registry personnel			Date
<input type="checkbox"/> Request approved by:			
<input type="checkbox"/> Request denied because:			
Information released:			

Persons or agencies with authored access to child abuse information must use this form to request information about a registered child abuse report. Complete a separate form for each family, or individual.

SECTION I: To be completed by the person or agency requesting the information.

Requester: Last First or Agency Name Link Associates			Telephone Number (515) 262-8888	
Street 1452 29 th Street		City West Des Moines	State Iowa	Zip Code 50322
Relationship to the persons listed in Section II or III				
I have read and understand the legal provisions for handling child abuse information which are printed on the back of this form. I understand that this request will not be approved unless I have authorized access.				
Signature of Requester			Date	

Complete Section II if the purpose of this record check is employment, licensing, or registration, or payment approval.

SECTION II: List the name and address whose record is being checked.

Last	First	Middle	Birth Date	Social Security Number
Street	City	County	State	Zip Code
List maiden name, any previous married names, and any alias;				

Complete Section III if the request is a copy of the written summary of the abuse investigation or assessment.

SECTION III: Request for written summary.

Parent's Name(s) Last	First	Middle	County	Birth Date	Social Security Number
Street			City	State	Zip Code
List maiden name, any previous married names, and any alias;					
Children's Name(s) (Attach additional pages if necessary)					
Last	First	Middle	County	Birth Date	Social Security Number

SECTION IV: Registry or designee decision.

This request for information is approved.

This request for information is denied because:

Signature of Requester	Date
------------------------	------

TO: Iowa Division of Criminal Investigation
 Bureau of Identification
 Wallace State Office Building
 Des Moines, Iowa 50319
 (515) 281-5138
 (515) 242-6876 (fax)

FROM: Link Associates

 1452 29th Street

 West Des Moines, IA 50322

Phone # (515) 262-8888

Fax # (515) 262-8655

I am requesting an **IOWA CRIMINAL HISTORY** check on:

(Type or Print Legibly)

REQUEST

[Redacted]	[Redacted]	[Redacted]
Last Name <small>(mandatory)</small>	First Name <small>(mandatory)</small>	Middle Name <small>(recommended)</small>
[Redacted]	[Redacted]	[Redacted]
Date of Birth <small>(mandatory)</small>	Sex <small>(mandatory)</small>	Social Security Number <small>(recommended)</small>
[Redacted]		
Signature of Requester		

There is a separate Form "C" required for each last name submitted

(DCI Use Only)

RESULTS

As of _____, a Name and date of birth check revealed:

CCH record attached No CCH record found

DCI initials _____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation.

[Redacted]	[Redacted]
Signature	Date

Form No. 595-1490 (10/99)

LINK ASSOCIATES

Request for Confirmation of Driving Record

Date of Request: _____

Applicant / Employee: _____

Social Security No: _____

Driver's License No: _____ **State:** _____

Expiration Date: _____

I, _____, give my permission for Link Associates to verify my driving record with the Iowa Department of Transportation.

Applicant / Employee

Department Head



Results / Comments:

Date

Safety/ Transportation Administrator

Acknowledgement of Transportation Policy

Whenever available, employees may use agency vehicles to conduct agency business. The Agency (Link Associates) maintains collision and liability insurance for all Agency vehicles used by staff and volunteers in transporting passengers and/or materials.

Employees of the Supported Employment Work Services program are required to transport consumers in their own vehicles as indicated in their job descriptions, and thus are bound by applicable policies and procedures. Care Providers with Family Support Services program and all other agency employees are not mandated to transport consumers in their own vehicle, but are bound by applicable agency transportation policies and procedures if they choose to transport consumers in their own vehicle.

The Agency requires evidence of automobile liability insurance on file if employees or volunteers are transporting consumers in their own vehicle, or will be conducting Agency related business in their own vehicle. The Agency recommends employees or volunteers maintain auto liability limits of at least \$300,00 Combined Single Limit Bodily Injury and Property Damage per occurrence. Employees or volunteers are not to transport consumers in another individual's vehicle.

The Agency does not provide any liability or physical damage insurance for vehicles owned by employees or volunteers. The employee or volunteer will be paid a certain amount per mile for their business use miles. This payment is designed to cover expenses, including insurance, for the operation of their personal auto for agency business. The Agency will not pay for any deductible amount that the employee or volunteer may have to pay for physical damage loss to their vehicle while on agency business. The Agency has no insurance and will not pay for any vandalism to employee or volunteer personal vehicles while parked in any agency parking lot.

I, _____, have read the above policy and agree to abide by the policy.
(Print First and Last Name)

Date: _____ Signature: _____

ATTACH: Copy of personal auto insurance, if applicable.

Application # _____

Date _____

Link Associates Applicant Survey

Link Associates is committed to Equal Opportunity Employment and Affirmative Action principles. The following information will only be used for program evaluation, reporting requirements and affirmative action referrals. This information is confidential. If you decide to provide this, it will NOT adversely affect you as an applicant. This section is removed before your application is processed. Applicants found to have falsified applicant survey information will be subject to the penalties listed on the bottom of the application form.

Submission of this information is voluntary

PLEASE WRITE YOUR NUMBERED RESPONSES IN THE CORRESPONDING BOXES.

A) Position applied for:

- 0) Administration
- 1) Case Management
- 2) Clerical
- 3) Residential Counselor/Life Coach
- 4) Respite Care Provider
- 5) Other _____

B) What is your age?

- 0) Under 18
- 1) 18-29
- 2) 30-39
- 3) 40-49
- 4) 50-59
- 5) 60-69
- 6) 70 or over

C) What gender are you?

- 0) Male
- 1) Female

D) Do you have a disability that is a physical or mental impairment that substantially limits one or more major life activities; do you have a record of having such an impairment; or are you regarded as having such an impairment?

- 0) No
- 1) Yes

E) Of which racial/ethnic group do you consider yourself as a member?

- 0) African American or Black: Origins in any of the black racial groups of Africa
- 1) Asian: Origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent
- 2) Caucasian: Origins in any of the original peoples of Europe, North Africa or the Middle East
- 3) Latino: Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- 4) Native American/ Alaskan Native: Origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition
- 5) Native Hawaiian or Other Pacific Islander: Origins in any of the original peoples of Hawaii or the Pacific Islands

Waive Disclosure: I do not wish to provide any of the above information. _____
Initials Date