Missouri Department of Health and Senior Services
Family Care Safety Registry
Memorandum of Agreement

MOA Number (Internal Use Only)

The Missouri Department of Health and Senior Services (DHSS) and _____, hereinafter referred to as Provider, do hereby enter into the following agreement to identify roles and responsibilities related to utilizing the Family Care Safety Registry (FCSR) Internet Background Screening Request System. The following terms are agreed upon as follows:

The DHSS shall:

1. Grant access to the FCSR Internet Background Screening System to eligible employees of Provider who is licensed or contracting with the DHSS. Access shall be used for the sole purpose of meeting legal requirements for background screening of employees.
2. Provide ongoing user support to Provider employee.
3. Terminate access to the FCSR Internet Background Screening System to any Provider employee who has not utilized their access for thirty (30) consecutive days.

The Provider shall:

1. Ensure that all Provider employees requesting access to the FCSR Internet Background Screening System are registered with the FCSR and are not listed on any background screening database accessed by the FCSR.
2. Request access for individuals who are employed in good standing with Provider in a direct employer-employee relationship.
3. Ensure that Provider shall notify DHSS within 24 hours of any change in Provider employee's employment status requiring removal/replacement of the Provider employee currently permitted access. Failure to report changes within designated timeframe may result in termination of Memorandum of Agreement.
4. Ensure that information obtained from the FCSR Internet Background Screening System is obtained for employment purposes only as identified in section 210.921, RSMo, and understand that misuse of information is a class B misdemeanor.
5. Ensure that confidential information obtained through the FCSR Internet Background Screening System is protected as required by applicable state and federal laws and accept liability for any and all breaches of confidentiality.
6. Ensure that Provider employees shall not share passwords issued by DHSS with any other individual. Failure to comply with this provision will result in immediate termination of this agreement.
7. Complete the attached organization/facility information sheet for information to be maintained in the FCSR database, and communicate changes in information to the FCSR in a timely manner.

Either party may terminate this agreement with 30 days prior written notice.

The parties hereto have signed this Memorandum of Agreement on the date indicated.

PROVIDER	
Authorized Signature	**Title**
Provider/Agency Name	**Date**
Provider License/Contract Number	**Provider Licensing Agency**
DEPARTMENT OF HEALTH AND SENIOR SERVICES	
Authorized Signature	**Title**
Division	**Date**

Missouri Department of Health and Senior Services
Family Care Safety Registry
Memorandum of Agreement Attachment – Organization or Facility Information

Provider/Agency Name (Include DBA name, if applicable.):

_____

Parent Company Name (if applicable):

_____

Mailing Address:

_____
Street Address or PO Box

_____
City

_____
State Abbrev. ZIP Code County

Telephone: Fax:
( ) - ( ) -

Main Contact Information:

_____
Name and Title

Telephone Number for Main Contact (if different than above):
( ) - ext.

Email Address (optional):

_____

Which type(s) best describe your organization or facility? (Check all that apply.)

- ☐ Child Care Center
- ☐ Family Child Care Home/Group Home
- ☐ Child Placement Service (Adoptive/ Foster Care)
- ☐ Children's Home/Residential Facility
- ☐ State or Local Government Agency
- ☐ School: K – 12
- ☐ School: College/Technical/University
- ☐ Non-Emergency Medical Transport
- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Skilled Nursing Facility
- ☐ Nursing Facility
- ☐ Residential Care Facility
- ☐ Intermediate Care Facility
- ☐ Intermediate Care Facility/MR
- ☐ Personal Care: CDS/CIL
- ☐ Personal Care: In-Home Svcs.
- ☐ Personal Care: HCY/PDW/DDD/Oth.
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Hospital: LTAC or Swing Bed
- ☐ Other Long Term Care Provider
- ☐ General Hospital
- ☐ Mental Health/Psychiatric Hospital
- ☐ Other Health Care Provider
- ☐ Other (Please list): _____

If more than one type selected above, which one is primary? (Please list.) _____

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