

PHONE # 409-584-2655

WEST SABINE ISD
 P.O. BOX 869
 PINELAND, TEXAS 75968

FAX# 409-584-2139

Work Experience	Employer name and location		Employer name and location		
	Position/title held		Position/title held		
	Dates employed		Dates employed		
	Supervisor's name and phone		Supervisor's name and phone		
	Reason for leaving		Reason for leaving		
References	Please list references the district can contact regarding your work history.				
	Full name of reference	School district/ firm name	Mailing address	Position/title	Area code/ phone number
Education/Training	List the highest level of education attained: _____				
	Licenses and certificates granted _____				

	Name and location of schools attended	Course of study and major/minor	Diploma, degree, certificate, or license granted		Year graduated <i>(College only)</i>

General Information	<p>Do you have a relative who serves on the Board of Education or is an employee of West Sabine ISD?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the relative's name and relationship: _____</p> <p>_____</p> <p>Have you ever been convicted of, pled guilty or no contest (nolo contendere) to, or received probation, suspension, or deferred adjudication for a felony or any offense involving moral turpitude (including, but not limited to, theft, rape, murder, swindling, and indecency with a minor)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please state where, when, and the nature of the offense _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(A felony conviction is not an automatic bar to employment. The district will consider the nature, date, and relationship between the offense and the position for which you are applying.)</p>
Verification	<p>I hereby affirm that all information provided in this application is true and accurate to the best of my knowledge and understand that any deliberate falsifications, misrepresentations, or omissions of fact may be grounds for rejection of my application or dismissal from subsequent employment.</p> <p>I authorize the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all such parties from liability for any damage that may result from furnishing the same to you.</p> <p>I understand that the district is required by Texas Education Code to review criminal history of applicants.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature Date</p> <p>This application becomes the property of the district.</p>

**Applicants for all positions are considered without regard to race, color, national origin, religion, sex, marital status, veteran or military status, disability, or any other legally protected status*

The district Title IX Coordinator is Mike Pate
101 Timberland
P.O. Box 869
Pineland, Texas 75968
409-584-2655

CRIMINAL HISTORY INFORMATION REQUEST

Confidential*

The West Sabine Independent School District is required by Texas Education Code Chapter 22, Subchapter C to review the criminal history of applicants, employees, independent contractors, student teachers, and certain volunteers. The information requested below is necessary to obtain criminal history record information.

Please print.

Name _____
Last First Middle

Social Security Number _____ Date of birth _____

Driver's License _____
State and Number

Mailing Address _____
Street City State Zip

Sex: Male Female

Ethnicity: Black White/Other

I understand that the information I am providing about age, sex, and ethnicity will not be used to determine eligibility for employment but will be used *solely* for the purpose of obtaining criminal history record information.

I understand before I can work for West Sabine ISD I must be fingerprinted. I also understand I am responsible for any expenses incurred in this process. Please check one of the following:

_____ Begin the fingerprint process.

_____ Do not begin the fingerprint process at this time. I will notify you later.

Signature

Date

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, have been notified that a Computerized Criminal History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply.

Because the name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization conducting the criminal history check for background screening is not allowed to discuss any criminal history record information obtained using the name and DOB method. Therefore, the agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (Automated Fingerprint Identification System). I have been made aware that in order to complete this process I must make an appointment with L1 Enrollment Services, submit a full and complete set of my fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$24.95 to the fingerprinting services company, L1 Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date

WEST SARBINE ISD

Agency Name (Please print)

CARLA POWELL

Agency Representative Name (Please print)

Carla Powell

Signature of Agency Representative

07/2/12

Date

**Please:
Check and Initial each Applicable Space**

CCH Report Printed:

YES NO _____ initial

Purpose of CCH: _____

Hire Not Hired _____ initial

Date Printed: _____ initial

Destroyed Date: _____ initial

Retain in your files



WEST SABINE INDEPENDENT SCHOOL DISTRICT

PO BOX 869

PINELAND, TX 75968

PHONE: 409-584-2655 FAX: 409-584-2139

West Sabine ISD provides health coverage to employees through TRS-ActiveCare. A district substitute is eligible to enroll in TRS-ActiveCare if the district reasonably expects the substitute to work at least 10 hours per week. Hours worked for other school districts are not considered in determining whether a substitute is eligible for benefits through West Sabine ISD.

Although the district reasonably expects substitutes to work at least 10 hours per week, the district does not guarantee that you will receive 10 hours every week. The district's need for substitutes varies from week to week. In some weeks, you may not receive any assignments. Similarly, the district understands that some weeks you may not be able to accept assignments due to illness or other personal reasons.

If you are a new substitute, you must enroll in or decline medical coverage within 31 days from date of hire. If you are a returning substitute, you must enroll in or decline medical coverage during the annual open enrollment. If you decline coverage, you cannot enroll again until the next plan year unless you experience a special enrollment event.

If you elect to enroll, you will be responsible for the full premium. You must submit payment for one calendar month with your enrollment form. The premiums for subsequent months will be deducted from your pay for the preceding month. If your pay is not sufficient to cover the full premium, you must submit the difference to the district by the 25th day of the preceding month. If the 25th day falls on a weekend or a day the district is closed, the payment must be made the preceding business day. If you fail to timely pay the monthly premiums, the district will proceed with the coverage cancellation process. Your coverage may also be cancelled if you lose eligibility for TRS-ActiveCare.

You may be removed from the district's substitute roster for poor performance or misconduct. In addition, you may be removed from the substitute roster if:

- you repeatedly turn down assignments, are repeatedly unavailable for calls, or frequently cancel assigned positions
- you do not accept at least 10 assignments per year
- you do not timely return a letter of reasonable assurance

A substitute who is enrolled in TRS-Active Care and who is then removed from the substitute roster becomes ineligible for health coverage and will be provided notice regarding continuation coverage under COBRA (if eligible). Cancellation due to non-payment is considered a voluntary drop: Therefore you would not be eligible for COBRA.

If you have any questions or need additional information regarding this matter, please call Sherry Boyett or Natasha McClelland at 584-2655. Thank you.

Sincerely,



Mike Pate
Superintendent

The West Sabine Independent School District does not discriminate against any employee or applicant for employment because of race, color, religion, sex, age, national origin, disability, military status, or on any other basis prohibited by law. Employment decisions will be made on the basis of each applicant's job qualifications, experience, and abilities.



Enrollment Application and Change Form



ELIGIBILITY: Are you an active employee and making monthly contributions to TRS? ... (If no to both, you are not eligible for TRS-ActiveCare coverage)

SECTION 1: ENROLLMENT/CHANGE TRANSACTION TYPE
Annual Enrollment, New Employee, Add Dependent, Special Enrollment
Special Enrollment Event Date, Marriage, Court Order, Birth/Adoption, Loss of Coverage, Other
Change Only, Decline Coverage, Cancel Employee, Cancel Dependent

SECTION 2: EMPLOYEE INFORMATION
Last Name, First Name, MI, Social Security #
Mailing Address, City, State, Zip
Home Phone Number, Cell Phone Number, Email
Date of Birth, Sex, Language, Ethnicity
Do you have a disability affecting your ability to communicate or read?
Is the Employee Covered By Other Insurance?
Is the Employee Covered by Medicare?
Reason for Medicare Coverage

SECTION 3: COVERAGE SELECTION (Please select a Plan of Coverage and Coverage Type)
PPO Selection: ActiveCare 1-HD, ActiveCare Select, ActiveCare 2
HMO Selection: FirstCare, Scott & White Health Plan, Valley Baptist Health Plan
Coverage Type Selected: Employee Only, Employee + Spouse, Employee + Child(ren), Employee + Family

SECTION 4: DEPENDENT INFORMATION (Use additional form for additional dependents)
SPOUSE Last Name, First Name, MI, Street Address, City, State, Zip, Phone Number, Sex, Date of Birth, Social Security #, Other Insurance
CHILD Last Name, First Name, MI, Street Address, City, State, Zip Code, Phone Number, Date of Birth, Social Security #, Sex, Other Insurance

PLEASE CONTINUE ON NEXT PAGE

CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address: <input type="checkbox"/> Same as Employee				
City:		State:	Zip Code:	Phone Number:
Date of Birth:		Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Other Insurance: <input type="checkbox"/> Yes, Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				

CHILD Last Name:		First Name:		MI:
<input type="checkbox"/> Natural/Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Disabled <input type="checkbox"/> Other				
Street Address: <input type="checkbox"/> Same as Employee				
City:		State:	Zip Code:	Phone Number:
Date of Birth:		Social Security #:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Other Insurance: <input type="checkbox"/> Yes, Carrier/Plan <input type="checkbox"/> No <input type="checkbox"/> Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				

SECTION 5: DISABLED DEPENDENTS OVER AGE 26 Dependent Child's Statement of Disability Attached

Please note that a Dependent Child's Statement of Disability form is required for coverage of a disabled child over age 26. See your Benefits Administrator for the form, which must be completed in full and submitted to your Benefits Administrator.

SECTION 6: DECLINATION OF COVERAGE

This is to certify that the available coverage has been explained to me. I have been given the opportunity to apply for the coverage available to me and my dependents and have voluntarily elected to decline the coverage as elected below.

Name:	SSN:	<input type="checkbox"/> Employee	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Spouse	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:
Name:		<input type="checkbox"/> Child	Reason:	<input type="checkbox"/> Other Coverage	<input type="checkbox"/> Other:

SECTION 7: COVERAGE CONDITIONS

- I am employed by the Employer named in this Enrollment Application and Change Form. I am eligible to participate in the coverage(s) offered by the TRS-ActiveCare program which is administered by Aetna, with HMO benefits provided by SHA, L.L.C. dba FirstCare, Scott and White Health Plan, and Valley Baptist Insurance - Company dba Valley Baptist Health Plans. On behalf of myself and any dependents listed on their Enrollment Application and Change Form, I apply for those coverage(s) for which I am eligible.
 - If I am enrolling a grandchild in Section 4, I certify that my household is the grandchild's primary residence and the grandchild is my dependent for federal income tax purposes for the reporting year in which coverage of the grandchild is in effect.
 - If I am enrolling a child as an "other Child" in Section 4, I certify that my household is the child's primary residence, that I provide at least 50% of the child support, that neither of the children's natural parents reside in my household, and that I have the legal right to make decisions regarding the child's medical care.
- Only those coverage(s) and amount for which I am eligible will be available to me. I understand that if this Enrollment Application and Change Form is accepted, the coverage(s) will become effective in accordance with the provisions or the TRS-ActiveCare program.
- I understand that by enrolling for coverage with Employer named in the Enrollment Application and Change Form that any TRS-ActiveCare coverage I previously elected under another TRS-ActiveCare participating district/entity will be terminated under TRS Rules.
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.
- I understand that by declining TRS-ActiveCare coverage now or by terminating TRS-ActiveCare coverage during the plan year, I am not eligible to re-enroll in TRS-ActiveCare until the next plan year, unless I experience a special enrollment event.
- I state that the information given on the Enrollment Application and Change Form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).

Applicant Signature: X _____ Date: _____

SECTION 8: SPECIAL NOTES REGARDING MY ENROLLMENT (Please indicate any special information regarding my enrollment for Aetna, Caremark or my selected HMO)