

Alaska Background Check Application & Instructions

An application cannot be submitted without the **Provider Identification Number** which is a unique identifier giving Division authorization for an agency to submit fingerprints. If you do not have this information, contact the BCU office at (907) 334-4475.

This form is created in an Adobe format. Once you have completed the form, please print and mail or fax the form to:

State of Alaska/Dept of H&SS
Division of Public Health
Background Check Unit
619 E. Ship Creek Ave., Ste. 232
Anchorage, AK 99501
(907) 269-3488 FAX

If you are filling out this application on a computer, use the drop down menus to assist you in completing this form.
If you are filling out a printed version, follow the instructions for the fields below:

State Program (choose from the options below):

Adult Day Care; Adult Respite; Ambulatory Surgical Center; Assisted Living Homes - Medicaid Certified - Serving 8 or less; Assisted Living Homes - Medicaid Certified - Serving 9 or more; Assisted Living Homes - Non Medicaid Certified; Care Coordination; Case Management; Child Care Facility; Child Placement Facility; Day Treatment Center; Direct Entry Midwifery Birth Center; End-stage Renal Disease Center; FAS Grantees; Foster Home; Free-Standing Birth Center Hospice; Hospital; Intermediate Care Facility for the Mentally Retarded; Long Term Care Hospital with Swing Beds Maternity Home; Outpatient Physical Therapy; Outpatient Speech Therapy; Personal Care Agency; Residential Psychiatric Treatment Center; Runaway Shelter; Rural Health Clinic; Skilled Nursing Facility / Nursing Facility; Supported Living Home; Substance Abuse Treatment Facility; Specialized Hospital.

State Division (choose from the options below):

Behavioral Health; Health Care Services; Juvenile Justice; Office of Children's Services; Pioneer Home; Public Assistance Public Health; Senior and Disabilities Services.

Position Status (choose from the options below):

Director; Employee; Independent Contractor; Individual Having Regular Contact Who is **not** a Family Member or Visitor of a Recipient of Services; Member or Principal of the Business; Organization that Owns an Entity; Officer; Operator; Owner; Partner; Resident 16 years of age or older; **Not** a Recipient of Services; Volunteer - Unsupervised.

Position Title (choose one of the main titles below):

Executive, Administrative, Managerial - Includes:

Clerical, Director, Business Manager, Nursing Home Administrator, or Other Executive, Administrative, Managerial Employee Categories.

Professional Licensed Health Care - Includes:

Dentist, Dietitian, LPN, LVN, RN, Medical Director, Mental Health Professional, Occupational/Vocational Therapist, Pharmacist, Physical Therapist, Physician, Physician Extender, Podiatrist, Social Worker, Speech/Language Pathologist, Other Professional/Licensed Employee Categories.

Technical Unlicensed Health Care

Feeding Assistant, Medication Aide/Technician, Nurse Aide, Nurse Aide in Training, Occupational/Vocational Therapy Aide, Occupational/Vocational Therapy Assistant, Orderly/Attendant, Personal Care Worker, Physical Therapy Assistant, Physical Therapy Aide, Other Technical, Unlicensed Employee Categories.

Laboratory/Radiology Services

Laboratory Technician, Radiology Technician, Other Laboratory or Radiology Employee Categories.

Food Services

Cook, Kitchen Worker, Food Preparer, Waiter, Waitress, Other Food Service Employee Categories.

Housekeeping Services

Cleaner, Janitor, Maid, Other Housekeeping Employee Categories .

Other

Any other job title which does not fall under one of the above categories.

APPLICATION FOR BACKGROUND CHECK

All fields are required to be completed prior to submitting

<input checked="" type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Other			FMH-FAI02242300001 Provider Identification Number		
Fairbanks Memorial Hospital/Denali Center		Pattie Gill	(907) 458-5368	(907) 458-5572	
Name of Agency/Facility		Point of Contact	Phone Number	Fax Number	
1650 Cowles Steet		Fairbanks	AK	99701	pattie.gill@bannerhealth.com
Mailing Address		City	State	Zip Code	E-Mail Address
Hospital State Program			Public Health State Division		
<p>Instructions: Complete a separate form for each individual sixteen (16) years of age or older of an entity who owns, or is an officer, director, partner, member, or principal of the business organization that owns an entity; operators, employees, contractors, unsupervised volunteers, residents other than those receiving services, individuals having regular contact with residents who receive services, unless the individual is a family member or visitor of an individual who receives services, under the provisions of AS 47.05.310, which are the responsibility of the Department of Health and Social Services. Social security number is required to conduct background check. Failure to provide the information will result in application not being processed.</p>					
*Legal Last Name		*Legal First Name		Initial	Legal Suffix
*SSN		<input type="checkbox"/> Male <input type="checkbox"/> Female	Aliases, Maiden Name, Previous Married Name(s)		
Driver's License No & State	*Date of Birth	*Current Physical Residence Address			Apt/Unit/Spc #
Home Phone Number	Alternate Phone Number	City			State
		Zip Code	Month/Year Alaska Residency Began		
*Mailing Address (if different from physical address))		Apt/Unit/Spc #	City	State	Zip Code
<p>Please list your previous residence for the last ten (10) years. City, State, and Country (if outside the USA). Attach additional page(s) if necessary.</p>					
From (MM/YY)	To (MM/YY)	City	State	Country	
From (MM/YY)	To (MM/YY)	City	State	Country	
From (MM/YY)	To (MM/YY)	City	State	Country	
From (MM/YY)	To (MM/YY)	City	State	Country	
From (MM/YY)	To (MM/YY)	City	State	Country	
*Place of Birth - Country		*Place of Birth - City		Place of Birth - State/Province	
Position Title			Position Status		
Revised July 31, 2008					



Disclosure of Personal History & Release of Information Authorization

Case Number (Eight Digit Number)

Applicants are required to disclose any known civil or criminal information regarding them which would be a barrier to association with the entity which is submitting your application for background check under AS 47.05. or 7 AAC 10.900 – 7 AAC 10.990. Please attach additional pages, if necessary, to complete the required information.

Have you ever been charged with, convicted of, found not guilty by reason of insanity for, or adjudicated as a delinquent for, a crime listed in 7 AAC 10.905?

No Yes If yes, please describe: _____

Have you ever been found by a court or agency of this or another jurisdiction to have neglected, abused, or exploited a child or vulnerable adult under Children in Need of Aid (AS 47.10), Protection of Vulnerable Adults (AS 47.24), or Office of the Long Term Care Ombudsman (AS 47.62) or a substantially similar provision in another jurisdiction?

No Yes If yes, please describe: _____

Have you been found by a court or agency of this or another jurisdiction to have committed medical assistance fraud under Medical Assistance Fraud (AS 47.05.210) or a substantially similar provision in another jurisdiction?

No Yes If yes, please describe: _____

Have you appeared on the centralized registry established under Centralized Registry (AS 47.05.330) or a similar registry of this state or another jurisdiction?

No Yes If yes, please describe: _____

Release of information Authorization

I certify that the contents of this form and information provided with it are true, accurate, and complete. I understand that a willful misrepresentation of the information provided is cause for immediate denial or later revocation of authorization under Criminal History; Criminal History Check; Compliance (AS 47.05.310).

I, the undersigned, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, protective service and licensing records. I understand any person providing information or records in accordance with this authorization is released from any and all claims or liability for compliance. I understand that this information may otherwise be confidential and that I am waiving that confidentiality and any claim I may have with regard to release of these records. I understand information obtained through this Release of Information Authorization will be held in confidence in accordance with DHSS guidelines.

I, the undersigned, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

Applicant Signature	Date	Parent Signature (if applicable)	Date
Applicant Printed Name	Applicant SSN	Parent Printed Name	