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; Office of Children's Services; Public Assistance; Public Health; Senior and Disabilities Services.

Position Status (choose from the options below):

Director; Employee; Independent Contractor; Individual Having Regular Contact Who i**s 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 Catagories.

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 Catagories.

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 Catagories.

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

☐ *New* ☐ *Renewal* ☐ *Other*

Provider Identification Number

Name of Agency/Facility | **Point of Contact** | **Phone Number** | **Fax Number**

Mailing Address | **City** | **State** | **Zip Code** | **E-Mail Address**

State Program | **State Division**

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.**

*Legal Last Name	*Legal First Name	Initial	Legal Suffix	*SSN

Driver's License No & State	*Date of Birth	☐ Male ☐ Female	Aliases, Maiden Name, Previous Married Name(s)

Home Phone Number	Alternate Phone Number	*Current Physical Residence Address	Apt/Unit/Spc #

City	State	Zip Code	Month/Year Alaska Residency Began

*Mailing Address (if different from physical address))	Apt/Unit/Spc #	City	State	Zip Code

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.

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