Department of Health and Social Services

DIVISION OF HEALTH CARE SERVICES
Background Check Program

4601Business Park Blvd., Bldg K
Anchorage, Alaska 99503-7167
Main: 907.334.4475
Fax: 907.269.3488

Alaska Background Check Application

****Asterisks mark required fields. Applications will not be processed without complete information.***

Personal Information

Full Legal Name: _____ / / _____
*Last *First M.I. Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address:
_____
*Physical Street Address *Apartment/Unit #
_____
*City *State *ZIP Code

Mailing Address (if different than Permanent/ Physical Address):
_____
*Mailing Address *Apartment/Unit #
_____
*City *State *ZIP Code

Primary Phone: **( )** _____ Secondary Phone: **( )** _____

*Applicant's Email Address: _____

*SSN (or ITN) : _____
☐ This is an ITN

Demographic Information

*Race: (Asian, Black, White Native American, or Unknown) _____

*Gender: (Male, Female, Unknown, Other) _____

*Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) _____

*Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) _____

*Height: _____ **FT** **IN**

*Weight: _____ **Lbs.**

*Place of Birth (Country/State): _____

US Citizen(Y/N): _____

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: _____ Middle Name: _____

Last Name: _____ SSN/ITN: This is an ITN☐ _____

Date of Birth: (mm/dd/yyyy) _____

First Name: _____ Middle Name: _____

Last Name: _____ SSN/ITN: This is an ITN☐ _____

Date of Birth: (mm/dd/yyyy) _____

Background Check Application for: First Name: _____ Last Name: _____ DOB: _____

Prior Address History

Prior Addresses in the last 10 years: Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

State: _____ Year(s) From: _____ **to** _____

Pre-Employment Information

Pre-Employment Information: Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.

Provider Name: Catholic Social Services/ Family Disability Services

State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: Family-Directed Respite

Position Title: Independent Service Provider

Position Type: Independent Contractor
(Employee/Independent Contractor/Volunteer/Other)

Instructions

1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: https://nabcs.dhss.ak.local/bcpapplicant. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are $76.50 and are **not refundable.**
5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
7. A complete application includes this application form, non-refundable payment in the amount of $76.50, and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check 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 for Background Check will be held in confidence in accordance with DHSS guidelines.

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

_____ _____
Applicant Signature Date

Revised 10.10.2014