PETERSBURG
ALASKA

New Hire Process for Mountain View Manor Resident Assistant applicants:

1. Complete the attached Alaska Background Check paperwork:
    a. Application for Background Check form
    b. Release of Information form
    c. Certification of Positive Identification for Fingerprinting form

2. Call the Police station at 907-772-3838 to make an appointment for two fingerprint cards. Let them know that it will be charged to the Borough for Mountain View Manor. Take your completed paperwork with you.

3. Take the completed application and fingerprint cards to Shelyn at the Manor.

4. Call the Health Nurse at 907-772-4611 to schedule a TB test.

If you have any questions, you can call Shelyn's cell at 518-1410 or Becky at 772-5404.

Thank you!

Borough Administration
PO Box 329, Petersburg, AK 99833 – Phone (907) 772-4425 Fax (907)772-3759
www.ci.petersburg.ak.us

Department of Health & Social Services
Background Check Program

RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

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).

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

_____ _____
Applicant Printed Name Date

_____ _____
Applicant Signature Applicant SSN

_____ _____
Parent Printed Name, if applicable Parent Signature

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 **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 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

MOA02603100001
Provider Identification Number

Mountain View Assisted Living	Shelyn Bell	(907) 772-2445	(907) 772-2435
Name of Agency/Facility	**Point of Contact**	**Phone Number**	**Fax Number**

PO Box 1530	Petersburg	AK	99833	sbell@petersburgak.gov
Mailing Address	**City**	**State**	**Zip Code**	**E-Mail Address**

Assisted Living Home	Senior and Disabilities Services
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

CERTIFICATION OF POSITIVE IDENTIFICATION FOR FINGERPRINTING

THIS FORM IS TO BE COMPLETED BY THE PERSON TAKING THE FINGERPRINTS

INSTRUCTIONS:

This form is a required document to the application.

The document used to verify identification for fingerprints must be a government issued document (i.e. driver's license, military identification card).

Mail this completed form along with one (single) fingerprint card and $54.25 associated fee made payable to Department of Health & Social Services 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

_____
Name of Agency/Facility Fingerprints are Being Taken For

_____ _____ _____
Type of Identification Used | Identification Number | State of Issue

I certify I have verified at least one form of government issued picture identification and have positively identified:

_____ as the person being fingerprinted.
(print applicant's name)

_____ _____ _____
Signature of Fingerprinter | Printed Name | Date

Revised February 01, 2008