Oregon Health Authority

In-Home Care/Home Health Agency
Owner/Administrator Background Check Request

Name (last, first, middle):	DOB:	Gender: ◯ M ◯ F	Social Security # (SSN)*
All other names used (Include maiden name):		ODL or ID card #:	State:
Mailing address (Street/Apt#):		Home or message phone:	
City:	State:	ZIP:	

Street address (If different than mailing address):	City:	State:	ZIP:

Email address:

Agency name: **Agency city:**

☐	**In Home Care Agency**	☐	**Home Health Agency (please check the box that applies)**
☐	**Owner**	☐	**Administrator information (Please check the box that applies)**

During the past 5 years, have you been outside Oregon 60 days or more in a row?

◯ **Yes** ◯ **No** **If yes, list the locations and dates:**

City/state/country:	From (month/year):	Until (month/year):

Have you ever been charged, arrested and/or convicted of a crime?

◯ Yes ◯ No If yes, list all charges, arrests and/or convictions and the outcome regardless of how long ago. **(Attach additional pages if needed.)**

Date (or estimate):		List each charge, arrest or conviction:	County:	State:	Outcome:
1.					
2.					
3.					
4.					
5.					

Provide a detailed explanation for each charge, arrest and conviction noted above. If you have criminal history, the Health Care Regulation & Quality Improvement (HCRQI) program will weigh several factors to decide if you are fit for the license/position for which you are applying. Respond to the following questions for each charge, arrest and conviction and attach documentation to support your responses.

- What happened leading up to the charge, arrest, conviction or other history?
- What was your age at the time of charge, arrest, conviction or other history?
- List any requirements resulting from each charge, arrest or conviction.
- Describe any treatment, education and training specifically related to your history.
- How is your history relevant to your position?
- How has your life changed since your history?
- List other information you believe would be helpful to the HCRQI program in making a decision in this case.

1.	
2.	
3.	
4.	
5.	

I hereby certify that I am the above named individual and that the information provided is true and correct. I understand that a criminal records and abuse check will be completed on me. My signature authorizes the Health Care Regulation & Quality Improvement program to request and receive any juvenile, police, court or investigation reports needed to complete this background check. In the event potentially disqualifying abuse or other information is discovered, I may be notified at the address listed above and asked to provide additional information. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the license/position. I understand the check may be repeated during the time I hold this license/position.

Signature:_____	Date:_____

* As part of your application you are required to provide your Social Security Number pursuant to ORS 25.785