

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

Name (last, first, middle):	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # (SSN)*
All other names used:	ODL or ID card #:	State:	
Mailing address (Street/Apt #):		Home or message phone:	
City:	State:	ZIP:	
Email address:			
Agency name:		Agency City:	
<input type="checkbox"/> In Home Care Agency	<input type="checkbox"/> Home Health Agency (please check the box that applies)		
<input type="checkbox"/> Owner	<input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N		
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? <input type="checkbox"/> Y <input type="checkbox"/> N				
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:

CONFIDENTIAL

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 that 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](#)