Washington State Department of Social & Health Services
Transforming lives

Background Check Authorization

PROCESSING CODE
FINGER PRINTS REQUIRED

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)

1A. ENTITY REQUESTING THE BACKGROUND CHECK	1B. ENTIRE ADDRESS OF ENTITY LISTED IN BOX 1A	1C. NAME OF SECONDARY ENTITY
CCAP	**117 E 3RD ST, ABERDEEN, WA 98520**	

2. **REQUIRED:** NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK

PRINTED NAME: SIGNATURE:

3. **REQUIRED ONLY FOR DSHS STATE EMPLOYMENT**

DSHS POSITION NUMBER _____ **(WRITE NONE IF NONE)** DSHS JOB CLASSIFICATION: _____ PERSONNEL IDENTIFICATION NUMBER: _____

☐ Permanent appointment ☐ Non-permanent appointment ☐ Work study / student internship ☐ Volunteer ☐ Acting

4. **REQUIRED:** BCCU ACCOUNT NUMBER	5. DSHS ID NUMBER OR NAME
80000213	

SECTION 2. THIS SECTION IS FOR APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)

6. SOCIAL SECURITY NUMBER	7. **REQUIRED:** DATE OF BIRTH (MM/DD/YYYY)	8. PRINT YOUR E-MAIL ADDRESS

9. **REQUIRED:** PRINT YOUR NAME AS IT IS LISTED ON YOUR DRIVER'S LICENSE OR OTHER PHOTO ID. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST:	MIDDLE:	LAST:

10. **REQUIRED:** PRINT ALL OTHER FIRST, MIDDLE AND LAST NAMES YOU HAVE USED. WRITE N/A IN THE BOX IF YOU DON'T HAVE A NAME TO ENTER.

FIRST:	MIDDLE:	LAST:

REQUIRED: SELF DISCLOSURE QUESTIONS. SEE INSTRUCTIONS.

You must answer Questions 11A through 14. Attach an additional sheet of paper if you need to list additional crimes or pending charges.

11A. Have you been convicted of any crime? If yes, fill in the blanks below. ☐ Yes ☐ No

_____ Degree: _____ State: __ Conviction date: __/__/____

11B. Do you have charges (pending) against you for any crime? If yes, fill in the blanks below. ☐ Yes ☐ No

_____ Degree: _____ State: __

12. Has a court or state agency ever issued you an order or other final notification stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or vulnerable adult? ☐ Yes ☐ No

13. Has a government agency ever denied, terminated, or revoked your contract or license for failing to care for children, juveniles, or vulnerable adults; or have you ever given up your contract or license because a government agency was taking action against you for failing to care for children, juveniles, or vulnerable adults? ☐ Yes ☐ No

14. Has a court ever entered any of the following against you for abuse, sexual abuse, neglect, abandonment, domestic violence, exploitation, or financial exploitation of a vulnerable adult, juvenile or child? ☐ Yes ☐ No

- Permanent* vulnerable adult protection order / restraining order, either active or expired, under RCW 74.34.
- Sexual assault protection order under RCW 7.90.
- Permanent* civil anti-harassment protection order, either active or expired, under RCW 10.14.
  See instructions for description of "permanent."

15. **REQUIRED:** PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER **(WRITE NONE IF NONE)**	**REQUIRED:** PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID

16. **REQUIRED**

Have you lived in any state or country other than Washington State within the last three years (36 months)? ☐ Yes ☐ No

17. **A. REQUIRED:** PRINT YOUR MAILING ADDRESS WHERE WE CAN SEND YOU CONFIDENTIAL INFORMATION

APT. NO. CITY STATE ZIP CODE

B. REQUIRED: PRINT THE STREET ADDRESS WHERE YOU LIVE NOW (WRITE "SAME" IF YOUR STREET ADDRESS IS THE SAME AS YOUR MAILING ADDRESS)

APT. NO. CITY STATE ZIP CODE

C. REQUIRED: GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED

18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. I understand and agree my signature in box number 19 means:

- I give DSHS permission to check my background with any governmental entity and law enforcement agency.
- My background check result may include prior self-disclosure information and fingerprint results that are contained in the DSHS Background Check System and that this information will be reported as allowed by federal or state law.
- If a final finding is identified, DSHS will report only my name and that a final finding was identified on the background check result.
- DSHS will give my background check result to the persons or entities named in Section 1 and may release my background check results to other persons or entities when the law authorizes or requires DSHS to do so. Fingerprint rap sheets are provided if allowed by federal or state law.
- The entity requesting this background check must submit this form to the Background Check Central Unit within the timeframe required by the DSHS oversight program.

19. **REQUIRED:** YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.	20. **REQUIRED:** TODAY'S DATE (MM/DD/YYYY)

PROGRAM USE – FOLLOW INSTRUCTIONS PROVIDED BY YOUR DSHS OVERSIGHT PROGRAM

DSHS 09-653 (REV. 04/2015)

Washington State Department of Social & Health Services
Transforming lives

Background Check Authorization

PROCESSING CODE
NEW HIRE

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11000786	

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PROGRAM USE – FOLLOW INSTRUCTIONS PROVIDED BY YOUR DSHS OVERSIGHT PROGRAM

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633
Olympia WA 98504-2633
(360) 534-2000
https://watch.wsp.wa.gov

REQUEST FOR CONVICTION CRIMINAL HISTORY RECORD (RCW 10.97)

INSTRUCTIONS: PLEASE COMPLETE THIS FORM WHEN REQUESTING **CONVICTION** CRIMINAL HISTORY RECORD INFORMATION FROM THE IDENTIFICATION AND CRIMINAL HISTORY SECTION. MAIL REQUEST TO ADDRESS NOTED ABOVE WITH $35.00 CHECK OR MONEY ORDER OR COME TO OUR OFFICE AT 3000 PACIFIC AVENUE, OLYMPIA, WA. ***NOTE: IT MAY TAKE 7 TO 14 BUSINESS DAYS FOR RESPONSE WHEN MAILED. FOR AN IMMEDIATE RESPONSE, ACCESS OUR WEB SITE LISTED ABOVE TO CONDUCT YOUR CRIMINAL HISTORY REQUEST FOR $10.00 USING A CREDIT CARD.***

NOTARIZED LETTERS ARE AN ADDITIONAL $5.00 PER NOTARY SEAL ____ **Notarized Letter(s)**

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints. Applicant may be advised of inquiry.

A **SUBJECT INFORMATION:** **(Please type or print clearly)**

Applicant's Name: _____
Last First Middle

Alias/Maiden Name: _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Social Security Number: _____ Drivers Lic. Number/State _____/____
(optional)

WSP USE ONLY

B **REQUESTER INFORMATION:** (Please type or print clearly)

DATE: ____/ ____/ ____ _____
Mo. Day Yr. (print) Name/Title of Requester

PHONE No. (____) _____ _____
Requester's Signature

REQUESTER'S ADDRESS: (type or clearly stamp address)

_____
Requesting Agency

_____
Name

_____
Address

_____
City State ZIP Code

Right Thumb Print (Optional)

3000-240-569 (R 12/07)

Attachment C

Data Share Compliance

Exhibit B

Contractor Agreement on Nondisclosure of Confidential Information

This form is for contractors and other non-DSHS employees.

Washington State Department of Social & Health Services

CONFIDENTIAL INFORMATION

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, protected health information as defined by the federal rules adopted to implement the Health Insurance Portability and Accountability Act of 1996, 42 USC §1320d (HIPAA), and Personal Information.

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers, and any financial identifiers.

REGULATORY REQUIREMENTS AND PENALTIES

State laws (including RCW 74.04.060; RCW 70.02.020, and RCW 71.05.390) and federal regulations (including HIPAA Privacy and Security Rules; 42 CFR, Part 2; 45 CFR Part 431) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines. You may face civil penalties for violating HIPAA Privacy and Security Rules up to $50,000 per violation and up to $1,500,000 per calendar year as well as criminal penalties up to $250,000 and ten years imprisonment.

ASSURANCE OF CONFIDENTIALITY

In consideration for the Department of Social and Health Services (DSHS) granting me access to DSHS property, systems, and Confidential Information I agree that I:

1. Will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this agreement for any purpose that is not directly connected with the performance of the contracted services except as allowed by law.
2. Will protect and maintain all Confidential Information gained by reason this agreement against unauthorized use, access, disclosure, modification or loss.
3. Will employ reasonable security measures, including restricting access to Confidential Information by physically securing any computers, documents, or other media containing Confidential Information.
4. Have an authorized business requirement to access and use DSHS systems or property, and view its data and Confidential Information if necessary.
5. Will access, use and/or disclose only the "minimum necessary" Confidential Information required to perform my assigned job duties.
6. Will not share DSHS system passwords with anyone or allow others to use the DSHS systems logged in as me.
7. Will not distribute, transfer, or otherwise share any DSHS software with anyone.
8. Understand the penalties and sanctions associated with unauthorized access or disclosure of Confidential Information.
9. Will forward all requests that I may receive to disclose Confidential Information to my supervisor for resolution.
10. Understand that my assurance of confidentiality and these requirements do not cease at the time I terminate my relationship with my employer or the DSHS.

FREQUENCY OF EXECUTION AND DISPOSITION INSTRUCTIONS

This form will be read and signed by each non-DSHS employee who has access to Confidential information, and updated at least annually. Provide the non-DSHS employee signor with a copy of this Agreement and retain the original of each signed form on file for a minimum of six years.

SIGNATURE

PRINT/TYPE NAME	NON-DSHS EMPLOYEE'S SIGNATURE	DATE