



# BACKGROUND SCREENING Application for Exemption

**AUTHORITY:** In accordance with section 435.07, Florida Statutes, persons disqualified from employment *may be* granted an exemption from disqualification. The granting of an exemption does not change an individual's criminal history. It only provides eligibility for employment in a health care setting.

An individual seeking an exemption must demonstrate by clear and convincing evidence that an exemption from disqualification should be granted. The application will be reviewed and a decision made once **all** relevant documentation listed below has been received.

A person is **not eligible** to apply for an Exemption from Disqualification until:

- He/she has been lawfully released from confinement, probation or other sanction for a disqualifying misdemeanor criminal offense;
- At least **3 years after** he/she has been lawfully released from confinement, probation or other sanction for a disqualifying felony criminal offense.
- **Persons designated as sexual predators, sexual offenders or career offenders are not eligible** for an Exemption from Disqualification.

## **APPLICATION CHECKLIST:**

The following items **must** be included with this Application for Exemption from Disqualification:

- A current Level II screening was conducted by the Agency for Health Care Administration.
- A Level II screening needs to be conducted electronically through an approved live scan vendor. For more information and instructions for requesting a Level 2 screening visit: [http://ahca.myflorida.com/MCHQ/Long\\_Term\\_Care/Background\\_Screening/index.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml).
- Arrest reports** for each offense listed on the criminal history report. The arrest report is a detailed narrative that explains the reason for your arrest. Arrest reports may be obtained from the law enforcement (police department, sheriff's office, etc) agency that made the arrest.
- Court dispositions** for each offense listed on the criminal history report. Court dispositions may be obtained from the clerk of the court in the county in which you were arrested. The disposition is the court document that states what you were actually sentenced for and the conditions of your sentence.
- If you were given **probation or parole**, you will need a letter from the probation department with the following information **required for each offense**: the date you started probation or parole; the date you are scheduled to terminate probation or parole; if you are eligible for early termination of probation or parole; if you have violated probation or parole; and if so, what was the violation.
- Provide **3-5 letters of reference**. One reference letter must be from a current or most recent employer *on the employer's letterhead*. Other letters must be from individuals you have known for **at least two years** through contact at the workplace, community activities, education or training centers. Individuals providing a letter of recommendation should include their name, address and telephone number for verification or possible interview.
- Documentation of rehabilitation**. Rehabilitation includes successful completion of a court-ordered treatment or counseling program, educational or training certificates, proof of participation in community activities, special recognition or awards received.



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<b>AHCA Use Only</b>	
Date Received:	_____
Date 1 <sup>st</sup> Reviewed:	_____
Date Omissions Sent:	_____
Date Appl. Complete:	_____
Hearing? Y N	_____
Decision Date:	_____

**AUTHORITY:** In accordance with section 435.07, Florida Statutes, this application is submitted for an Exemption from Disqualification to seek employment in a health care setting for which employment was denied due to a disqualifying criminal history offense. Disclosure of your social security number is voluntary. The Agency for Health Care Administration shall use such information for purposes of internal identification.

**NOTE:** The granting of an exemption by any State Department (including this Agency) does not change the results of a background screening or clear the criminal history. The exemption only provides eligibility for employment despite the presence of a disqualifying offense(s).

If granted, an exemption **may be voided** if you receive a judgment on a new disqualifying criminal offense after the date the exemption is issued.

## 1. PERSONAL INFORMATION

Please select any of the following that apply:

- I am not a licensed or certified health care professional and I **applied** for employment with a health care provider in a position that does not require licensure or certification (i.e. Dietary, homemaker or companion sitter, home health aide, etc.) and must obtain an exemption before I can work.
- I am an owner, administrator or chief financial officer for a health care provider that is currently licensed or seeking licensure by the Agency.
- I have submitted an application for enrollment as a Medicaid Provider and have a disqualifying criminal offense that was identified during the background screening process.
- I am a licensed or certified health care professional and I applied for employment with a health care provider in a position that does not require licensure or certification. **NOTE:** If you are seeking an exemption to work as a CNA, RN, LPN or other licensed or certified position, please contact the appropriate licensing board at the Department of Health.

Last Name:		First Name:		Middle Name:		Maiden Name:	
Mailing Address:						Phone Number: <i>Please include Area Code</i>	
City:				State:		Zip:	
Social Security Number:				Date of Birth: <i>mm/dd/yyyy</i>		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
List All Prior Names, Aliases, AKAs:				Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Indian <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: (INDICATE HISPANIC AS BLACK OR WHITE BASED ON SKIN COLOR)			
<b>Have you applied for an exemption from disqualification with another state agency?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete the following:</i>							
State Agency where exemption request was submitted: (i.e. Department of Children and Families, Department of Health, etc.)							
Date application submitted:				Date of decision:			
<b>Exemption decision:</b> <input type="checkbox"/> Granted <input type="checkbox"/> Denied <input type="checkbox"/> Withdrawn <input type="checkbox"/> Still under review							
<b>NOTE:</b> Even if you have received an exemption from disqualification from another state agency, you are still required to apply for an exemption through this Agency. <b>Proof of exemption must be provided with the application.</b> The Agency will take into consideration any exemption that is granted through another state agency when making a decision.							

## 2. EMPLOYMENT INFORMATION

Name of Provider where you are employed or seeking employment:			
Street Address:		Phone Number: <i>Please include Area Code</i>	
City:	State:	Zip:	

Please select the type of health care provider for which you work or were denied employment due to your criminal history:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adult Day Care Center     | <input type="checkbox"/> Health Care Clinic          | <input type="checkbox"/> ICF/DD                                |
| <input type="checkbox"/> Adult Family Care Home    | <input type="checkbox"/> Health Care Services Pool   | <input type="checkbox"/> Nurse Registry                        |
| <input type="checkbox"/> Assisted Living Facility  | <input type="checkbox"/> Home Health Agency          | <input type="checkbox"/> Nursing Home                          |
| <input type="checkbox"/> Community Mental Health   | <input type="checkbox"/> Home Medical Equipment      | <input type="checkbox"/> Prescribed Pediatric Extended Care    |
| <input type="checkbox"/> Crisis Stabilization Unit | <input type="checkbox"/> Homemaker/Companion Service | <input type="checkbox"/> Residential Treatment Facility/Center |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Hospice                     | <input type="checkbox"/> Other: _____                          |

Please select the type of position you are seeking an exemption. **NOTE:** Nurses, Certified Nursing Assistants and other professions licensed or certified through the Department of Health (DOH) must apply for an exemption through the appropriate licensing board at DOH.

- |  |  |
|--|--|
| <input type="checkbox"/> Administrator                           | <input type="checkbox"/> Homemaker/Companion Sitter                    |
| <input type="checkbox"/> Chief Financial Officer                 | <input type="checkbox"/> Maintenance                                   |
| <input type="checkbox"/> Dietary                                 | <input type="checkbox"/> Nursing Assistant (non-certified)/Patient Aid |
| <input type="checkbox"/> Home Health Aide                        | <input type="checkbox"/> Relief Person                                 |
| <input type="checkbox"/> Owner / Operator w/ 5% or more interest | <input type="checkbox"/> Employee / Staff Person                       |
| <input type="checkbox"/> Mental Health Personnel                 | <input type="checkbox"/> Risk Manager                                  |

## 3. EMPLOYMENT HISTORY

Identify the name and address of each employer, supervisor, address, telephone number, dates of employment and your job responsibilities for the last 5 years. **Please explain any breaks in employment that exceed 3 months.** Attach additional sheets if necessary.

Current or Most Recent Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Reason for Leaving:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Reason for Leaving:			

Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Reason for Leaving:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Reason for Leaving:			
Employer:		Supervisor's Name:	
Address:		Telephone Number: (include area code)	
Job Title:	Employment Dates:		
Job Responsibilities:			
Reason for Leaving:			

#### 4. EDUCATION / TRAINING

Please complete the following and include copies of any certificates, diplomas, and licenses if applicable.

1. What is your highest level education completed?

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Did not complete high school | <input type="checkbox"/> AA Degree       | <input type="checkbox"/> Doctorate    |
| <input type="checkbox"/> GED or equivalent            | <input type="checkbox"/> BS/BA degree    | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High School Diploma          | <input type="checkbox"/> Master's Degree |                                       |

2. Are you enrolled in or have you completed a training program to obtain certification or professional licensure in a health-related occupation?  Yes  No

If Yes, please complete the following:

Name of School/Program	Type of Training (Home Health Aide, Nursing Assistant, etc.)	Date of Training	Training Completed?	Certificate or License Received?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Are you a licensed or certified health care professional?  Yes  No

If yes, please provide your license or certificate number: \_\_\_\_\_

4. Have you registered for examinations required to obtain certification or professional licensure in a health related occupation?  Yes  No

If yes, please complete the following:

Type of Exam	Date Applied for Exam	Date of Exam

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### 5. CONFIRMATION TO REQUEST AN EXEMPTION REVIEW

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By submitting this application I formally request an exemption review in accordance with section 435.07, Florida Statutes. The information in this application and the documents I have provided are true and correct. I understand that it is my responsibility to provide clear and convincing evidence that I will not pose a danger to the health or safety of health care patients or their property. I also understand that the decision of the Agency for Health Care Administration regarding this exemption may be contested through a hearing requested under the provisions of Chapter 120, Florida Statutes.

I understand that information and documents submitted in this application are public records and shall be subject to public inspection as provided for in Chapter 119, Florida Statutes, except for information exempted by law from public viewing.

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**Please Print Your Name**

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**Signature**

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**Date**