Department of Health
BACKGROUND CHECK VARIANCE REQUEST APPLICATION

All variance request sections, and subsections of the Background Check Variance Request Application must be answered, and all required information attached. If any section and/or subsection is left blank or any other requested information is not included in the variance request, your request may be denied. Please double check to make sure all information is attached. Should you have any questions regarding the completion of a variance request, please contact the employer's/facility's oversight agency responsible for their licensing, certification, approval or finding of eligibility to receive payments for assistance.

Variance Request Application Deadlines (see 7 AAC 10.930 Request for a variance):

Variance request applications must be submitted to the Division office responsible for the employer's/facility's licensing, certification, approval, or finding of eligibility to receive payments. The request must be submitted no later than 90 days after the applicant and/or employer's/facility's receives notice that a barrier crime or condition exists for an individual or no later than 90 days after the Department denies a request for redetermination, if applicable. Applications can also be submitted to: bcpvariance@alaska.gov.

General Information:

The Department will not grant a variance for a crime or civil finding for which federal law prohibits certain approvals, or restricts payment of benefits, during the most stringent barrier period set by federal law for that crime or civil finding. If you have questions about federal barriers, please direct those questions to bcpvariance@alaska.gov when you submit your application.

Final decisions on applications for background check variances are made by the Commissioner of the Department of Health or their designee. Prior to review by the Commissioner or their designee, applications for background check variance are reviewed by a representative from the applicable oversight division as well by a review committee appointed by the Commissioner. The review committee may request you to appear in person or by telephone for an interview. If, after looking at all the of available information, the review committee determines that the health, safety, and welfare of recipients of services will be adequately protected, the review committee will recommend that the Commissioner or their designee grant approval on the request for a background check variance. If the review committee determines that the health, safety, and welfare of recipients of services will not be adequately protected, the review committee will recommend that the Commissioner or their designee will deny the request for a variance. If you are identified with a permanent barrier crime and/or condition, the review committee must send its recommendation to the director of the oversight agency for an additional recommendation and comments before it is sent to the Commissioner or their designee for a final decision.

All decisions of approval, with or without conditions, must be posted in a conspicuous place where they can be readily viewed by persons interested in obtaining the services offered by the employer/facility.

APPLICATION

****All information must be legible and must include all relevant information as stated in the variance request application ****

1. I'm seeking a variance to:

☐ Become employed/volunteer with an employer or to continue my employment/volunteering with an employer.
☐ Become a household member who will reside in a licensed facility.
☐ Other (please describe):

2. Who is the Oversight Division for the variance you are seeking?

☐ Behavioral Health
*Behavioral Health Treatment
*Case Management
*Residential Chemical Treatment
*Substance Use Treatment

☐ Health Facilities Licensing and Certification
*Ambulatory Surgical Center
*End Stage Renal Disease
*Outpatient Physical, Speech, and/or Occupation Therapy
*Freestanding Birth Center
*Home Health Agency
*Hospice Agency
*Hospital
*Nursing Facility
*Rural Health Clinic (including Frontier Extended Stay Clinic)

☐ Residential Licensing
*Assisted Living Home
*Residential Child Care Facility

☐Senior and Disabilities Services
*Home and Community-Based Wavier Services
*Personal Care Agency

☐ The Child Care Program Office
*Child Care Facilities

3. Your Information (Name of Individual Seeking a Variance):

Background Check Number:_____
Note: This number is located on the barring letter issued to you by the Background Check Program. *

Name (First, Middle, Last):_____

Physical Address:_____

State:_____ Zip Code:_____

Mailing Address:_____

State:_____ Zip Code:_____

Phone Number:_____ Date of Birth:_____

Email Address: _____

Preferred Contact Method: ☐ Email ☐ Phone ☐ Mail

Amount of time that has passed since your most recent barrier crime and/or condition? _____

What job title/position are you seeking a variance for?_____

How would you like to be notified of your variance decision? ☐ Secured Email (fastest) ☐ Mail

4. Employer/ Facility Information (if known):

Name:_____

Physical Address:_____

State:_____ Zip Code:_____

Mailing Address:_____

State:_____ Zip Code:_____

Phone Number:_____

Contact Name:_____

Contact Phone Number: _____

Contact/Notification Email Address:_____

The Department does not release the variance decision to your Employer/Facility without your permission. Do you give the Department permission to notify your Employer/Facility of your variance decision?

****Note: The Employer/Facility will receive this notification at the contact email address above ****

☐ I give permission to the Department to release my variance decision to my Employer/Facility.
☐ I **do not** give permission to the Department to release my variance decision to my Employer/Facility.

5. **Provide a detailed statement regarding your barrier crime(s) and/or condition(s) including any factors that may have contributed, at that time, to your barrier crime(s) and/or condition(s). This should include information regarding what happened prior to, during, and after the barrier crime(s) and/or condition(s). Attach additional pages if needed.**

6. **Provide a detailed statement describing all actions you have taken to prevent similar barrier crime(s) and/or condition(s) from occurring. Attach additional pages if needed.**

7. Provide a detailed statement as to why the Department should grant you a variance. You may attach additional statements from your Employer/Facility with their own rationale as to why you should be granted a variance.

8. If your mental health was a factor in your barrier crime(s) and/or condition(s), provide a detailed statement describing what steps you have taken to address your mental health.

☐ **Mental health was not a factor in my barrier crime(s) and/or condition(s).**

9. **If substance use was a factor in your barrier crime(s) and/or condition(s), provide a detailed statement describing what steps you have taken to address your substance use.**

☐ **Substance use was not a factor in my barrier crime(s) and/or condition(s).**

10. **If domestic violence was a factor in your barrier crime(s) and/or condition(s), provide a detailed statement describing the circumstances of the incident(s).**

☐ **Domestic violence was not a factor in my barrier crime(s) and/or condition(s).**

11. **Provide a job description and/or detailed statement describing the job duties and/or other responsibilities related to the variance you are seeking. Include the hours and days you will be performing the described job duties and/or responsibilities.**

12. Provide a detailed statement describing what you and/or your Employer/Facility will do to ensure that the health, safety, and welfare of the individuals receiving services will be adequately protected.

13. If you hold a professional license and/or certification such as a Registered Nurse license, Physician's license, Certified Nurse Aid certification, etc, attach a copy to this application. Please select the statements that applies:

☐ I have never held a professional license and/or certification in Alaska or any other state.

☐ My professional license or certification is currently valid and was first issued before the Department determined a barrier crime or condition existed and before being convicted of a criminal offense and have attached a copy of the license/certification.

☐ My professional license and/or certification is currently valid and was issued after the Department determined a barrier crime or condition existed and after being convicted of a criminal offense and have attached a copy of the license/certification.

☐ My professional license and/or certification no longer valid. Please explain why the license and/or certification is no longer valid and/or why you have not attached a copy of your current license.

14. Does the position for which you are seeking a variance involve direct contact with recipients of services? ☐ Yes ☐ No

15. Who would be supervising you from your Employer/Facility?

Name:_____ Position:_____ **☐ Not Applicable**

16. Does the position for which you are seeking a variance require you to transport recipients of services? ☐ Yes ☐ No

17. Do you have any outstanding restitution due to your barrier crime(s) and/or condition(s)? ☐ Yes ☐ No
If yes, attach your restitution repayment agreement or a description of your plan to repay the outstanding restitution.

18. Attach your resume or a detailed description of your educational and employment history.

19. If you have participated in any rehabilitation, prevention, or treatment efforts related to your barrier crime and/or condition, attach any available records which verify completion of those efforts.

20. Have you received a copy of your barrier determination letter or revocation noticed issued to you by the Background Check Unit? ☐ Yes ☐ No

21. Attach at least two letters of recommendation from individuals who are aware of your background history, mental health, substance use, and/or domestic violence incident, and would recommend a variance be granted for you. You may provide more than two if you choose. Letter of recommendation forms are provided at back of this application.

Letter of Recommendation Requirements.
~Must be from a person to whom you are not related.
~Must not be from a person associated with your Employer/Facility.

22. Provide all known and available records regarding your barrier crime(s) and/or condition(s) including:

~Protective orders.
~Charging documents.
~Conviction documents.
~Incarceration documents including your releases from incarceration, dates of release from incarceration, and any terms and conditions of parole.
~If you were sentenced and placed on supervised or unsupervised probation, a copy of the terms and conditions of probation.
~Any Release of Probation documentation.

Past Criminal History:

The applicant's past criminal history is reviewed regardless of whether that history has been identified as a barrier crime(s) and/or condition(s) to your employment.

23. Provide a detailed statement regarding any past incidents in which you have been involved <u>other</u> than the barrier crime(s) and/or condition(s) for which you are seeking a variance:

- Any protective order issued or filed under AS 18.66 (Domestic Violence and Sexual Assault) or a substantially similar law or ordinance of another jurisdiction.
- Any crimes for which you have been charged but not convicted.
- Any other crimes for which you have been convicted.
- Any indictments or presentments to which you were a party.
- Any incarceration for other crimes, including the date of your release.
- Any terms and conditions or release/parole.

SIGNATURE

By my signature below, I certify that the information contained in this application and applicable attachments is true, accurate, and complete.

Signature of Applicant Seeking a Variance:_____ Date:_____

Printed Name of Applicant Seeking a Variance:_____

Signature of Applicant's Legal Guardian
(Required if Applicant is under the age of 18 years of age):_____ Date:_____

Printed Name of Applicant's Legal Guardian if under the age of 18 years of age:_____

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

DIVISION OF HEALTH CARE SERVICES
Background Check Program

4601Business Park Blvd., Bldg. K
Anchorage, Alaska 99503-7167
Main: 907.334.2400
Fax: 907.561.1684

RELEASE OF INFORMATION FOR BACKGROUND CHECK VARIANCE

I, _____, am applying for a variance due to a barrier in my background.

I understand that there is a variance committee appointed by the Commissioners of Department of Health and Department of Family and Community Services.

I understand that the Background Check Program will share records relating to my background check with the variance committee, and I hereby give permission for the records to also be shared with the division responsible for oversight of this application, including civil court information, criminal justice, juvenile justice, child 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 by department employees through this Release of Information Authorization for Background Check Variance will be held in confidence and will not be re-released without my consent.

_____
Applicant Printed Name

_____
Applicant Signature

_____
Applicant SSN

_____
Date