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, supervision, or other nonmonetary condition imposed by the court for a **disqualifying misdemeanor** criminal offense;
- At least ***3 years after*** he/she has been lawfully released from confinement, supervision, or other nonmonetary condition imposed by the court for a **disqualifying felony** criminal offense.
- He/she has completed any court-ordered fee, fine, fund, lien, civil judgment, application, costs of prosecution, trust, or restitution as part of the judgment and sentence for any disqualifying felony or misdemeanor in full.
- **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 electronically through the Agency for Health Care Administration or the Care Provider Background Screening Clearinghouse by an approved live scan vendor. (For more information regarding Level II background screenings, please visit: http://ahca.myflorida.com/backgroundscreening.)

☐ **Arrest reports** for all offenses 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 all offenses 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.

☐ **Signed Statement** *(only needed if you cannot obtain the arrest report and/or court disposition)***:** Please write a detailed statement on each arrest explaining why you were arrested. You must include the victim's age and relationship to you and the sentence you received (probation, jail, prison, etc.). If your offense was related to theft, please include the item(s) and the approximate value of the item(s) stolen**.** *Documentation from the clerk of court and/or the arresting agency must be provided on letterhead indicating the document(s) are no longer available*. **Please make sure you sign the statement.***

☐ 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.

Where to send the application:

- The **Agency** reviews applications and makes decisions for Exemptions for:

    - **unlicensed personnel working for a health care provider**
    - **facility owner, administrator, or chief financial officer**
    - **Medicaid Provider Enrollment**
    - **Medicaid Managed Care Health Plan**

Send your application to:

Background Screening Unit

Agency for Healthcare Administration
2727 Mahan Drive MS #40
Tallahassee, FL
32308 (850) 412-4503

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*The **Department of Health** reviews applications and makes decisions for **licensed and certified health care professionals** as long as that person is working in the scope of his or her license or certification.*

For more information regarding the exemption process for licensed or certified individuals with the Department of Health, visit http://www.floridahealth.gov/ or by calling 850-245-4444.

AHCA Use Only

Date Received: _____ Date 1st Reviewed: _____
Date Omissions Sent: _____
Date Appl. Complete: _____
Hearing? Y N
Decision Date: _____

BACKGROUND SCREENING
Application for Exemption

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 clear the criminal history. The exemption only provides eligibility for employment despite the presence of a disqualifying offense(s). The exemption only provides eligibility for employment despite the presence of a disqualifying offense(s). If granted, an exemption* ***shall be voided*** *if you receive a new disqualifying criminal offense after the date the exemption is issued.*

1. PERSONAL INFORMATION

Please select any of the following that apply:

☐ 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.

☐ I am employed with a Medicaid Managed Care Health Plan. Principals of the provider entity include any officer, director, billing agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to 5 percent or more in the provider.

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: *Please include Area Code*	
City:		State:	Zip:
Email: Optional			
**Social Security Number:		Date of Birth: *mm/dd/yyyy*	Sex: ☐ M ☐ F
List All Prior Names, Aliases, AKAs:		Race: ☐ White ☐ Black ☐ Indian ☐ Asian or Pacific Islander ☐ Other: (INDICATE HISPANIC AS BLACK OR WHITE BASED ON SKIN COLOR)	

Have you applied for an exemption from disqualification with another state agency? YES NO

If yes, complete the following:

State Agency where exemption request was submitted: (i.e. Department of Children and Families, Department of Health, etc.)

Date application submitted:	Date of decision:

Exemption decision: ☒ Granted ☐ Denied ☐ Withdrawn ☐ Still under review

NOTE: *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.* ***Proof of exemption must be provided with the application****. 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:** *Please include Area Code*	
City:	**State:**	**Zip:**

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

- ☐ Adult Day Care Center
- ☐ Adult Family Care Home
- ☐ Assisted Living Facility
- ☐ Community Mental Health
- ☐ Crisis Stabilization Unit
- ☐ Durable Medical Equipment
- ☐ Health Care Clinic
- ☐ Health Care Services Pool
- ☐ Home Health Agency
- ☐ Home Medical Equipment
- ☐ Homemaker/Companion Service
- ☐ Hospice
- ☐ ICF/DD
- ☐ Nurse Registry
- ☐ Nursing Home
- ☐ Prescribed Pediatric Extended Care
- ☐ Residential Treatment Facility/Center
- ☐ 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.*

- ☐ Administrator
- ☐ Chief Financial Officer/
- ☐ Dietary
- ☐ Home Health Aide
- ☐ Owner / Operator w/ 5% or more interest
- ☐ Mental Health Personnel
- ☐ Risk Manager
- ☐ Homemaker/Companion Sitter
- ☐ Maintenance
- ☐ Nursing Assistant (non-certified)/Patient Aid
- ☐ Relief Person
- ☐ Employee / Staff Person
- ☐ Other: ____

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?
   - ☐ Did not complete high school
   - ☐ GED or equivalent
   - ☐ High School Diploma
   - ☐ AA Degree
   - ☐ BS/BA degree
   - ☐ Master's Degree
   - ☐ Doctorate
   - ☐ Other:

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?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ 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

5. CONFIRMATION TO REQUEST AN EXEMPTION REVIEW

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.

** Pursuant to § 837.06, F.S., whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his or her official duty shall be guilty of a misdemeanor of the second degree, punishable as provided in § 775.082, F.S., or § 775.083, F.S.*

*** The collection of social security numbers is imperative for the performance of the Agency's duties and responsibilities in accordance with § 119.071(5)(a)2.b., F.S., relating to health care provider licensure under § 408.809, F.S., and Medicaid enrollment under § 409.907, F.S. Your social security number will be used to secure the proper identification of persons listed on this application.*

Please Print Your Name

Signature **Date**