Mississippi Department of Mental Health
Division of Certification
Background Check Form

INSTRUCTIONS: This form should be utilized for all new employee hires, volunteers, and interns applying to work at an agency provider certified to provide services within the public mental health system for individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance use disorders (SUD), to ensure the required criminal background checks have been made. Please read carefully and complete this form. Background checks should be completed at the time of hire and must be verified before the employee, volunteer, or intern has any contact with people being served. If the agency provider provides Home and Community-Based Services (HCBS), national criminal background checks with fingerprinting must be conducted prior to employment and every two (2) years thereafter, in addition to monthly registry checks for Mississippi Nurse Aide Abuse Registry, Office of Inspector General's Exclusion Database, and Child Abuse Central Registry Check. The agency provider is responsible for maintaining proof of documented background checks and fingerprinting in writing for each employee, volunteer, or intern. Once a background check has been completed, noting that there were no disqualifying events, the agency provider is responsible for notifying the person in writing of such. Documentation must be maintained in the personnel file confirming no disqualifying events. (*Operational Standards* Chapter 11). Please type or print legibly. This form must be completed by the individual or governing body with the authority and responsibility for developing policies, procedures, and business practices for which the agency and its services will be operated. This may include the executive director, chairperson of the governing authority, owner, etc. All dates should include the month, date, and year. Original signatures must be included. If additional space is needed to respond, please provide the information as attachments and reference the applicable section. NOTE: This form should also be completed for each position outlined in the Interested Agency Provider Application and submitted as part of the Interested Agency Provider Application Packet.

Section A

Contact Information: Please include the contact information for the employee, volunteer, or intern for which the background check is being made.

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same as street address): _____

City: _____ State: _____ Zip Code: _____

Telephone Number (Primary): _____ (Secondary): _____

Email Address: _____

Section B

Background Checks: Answer the following about the employee, intern, or volunteer listed in Section A. Note: If the agency provider provides Home and Community-Based Services (HCBS), national criminal background checks with fingerprinting must be conducted prior to employment and every two (2) years thereafter, in addition to monthly registry checks for Mississippi Nurse Aide Abuse Registry, Office of Inspector General's Exclusion Database, and Child Abuse Central Registry Check.

- National Criminal History Background Check Completed: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

  _____

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- Vulnerable Adults Abuse Registry Check Completed: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

  _____

  _____

- Child Abuse Registry Check Completed: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

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- Mississippi Nurse Aide Abuse Registry Check Completed: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

  _____

  _____

- Office of the Inspector General's (OIG) Exclusion Database Completed: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

  _____

  _____

- Fingerprints run as part of the background check: Y/N _____
  Date of Completion: _____
  Were any disqualifying events confirmed? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

  _____

  _____

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- Has the agency provider verified with the respective credentialing entity/licensure board the status of any credential(s) which the employee, volunteer, or interns holds or has previously held? Y/N _____
  If yes, list credential held, license number and expiration of credential: _____

- Has the person identified in Section A ever been convicted for a felony offense against the law? Y/N _____
  If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

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***For Interested Providers: Applicants must include a signed statement of assurance from the agency Executive Director (or top-level administrator) confirming background checks have been completed on all agency leadership staff and that no disqualifying events were returned.**

Section C

Additional Information: Please provide any additional information the agency provider believes would be helpful in explaining the background checks for the individual identified in Section A.

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Section D

Certification of Completed Background Check: This certification is to be read, signed, and dated by the designated hiring agency provider. The individual signing must be the proprietor in the case of a sole proprietorship, the Executive Director or chair of the governing authority of a corporation, governmental entity, or individual identified and granted authority by the University.

I certify that this form and its attachments have been carefully completed and reviewed. To the best of my knowledge, the information contained in this application and its attachments is true, accurate and complete. I also certify that this individual has not provided service delivery or been alone with people receiving services unsupervised by agency provider personnel until after this form was completed and acceptable evidence was supplied to DMH.

Signature	Date

Type or Print Name and Title of Individual Signing

For DMH Use Only:
Received By: _____ **Date:** _____