



CORNERSTONE HOME CARE
Consumer Directed Personal Care Assistant (CDPCA) Program

CDPCA Application Packet

CDPCA Applicant Name (Please Print) _____

CDPCA Consumer name (Please Print) _____

Do you have a current CPR and First Aid card? (circle one) YES NO

You cannot begin work with your client until your Provisional background clearance is received, hire paperwork has been completed and submitted, and you have received the okay from the Human Resources Department or Community Coordinator.

There may be costs associated with the Background Check or fingerprinting that will be your responsibility before hire. Please check with your local office for information.

Please submit application and all applicable forms to the Human Resources Department in the Juneau office or to your local office. Contact us with any questions or concerns.

Cornerstone Home Care
8800 Glacier Hwy., Suite 111
Juneau, AK 99801

Phone (907) 586-6838
Toll free: 1-877-956-2273
Fax: (907) 586-8114

Employer Name and Address	Position Title/Duties Skills	Dates Employed	
		From	To
	Supervisor's Name:	Telephone:	Reason for leaving

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Summarize other employment related to this job: _____

Proficient with computers or other office Equipment? Yes No

SPECIFY: Types of computers, other electronic or mechanical equipment that you are qualified to operate or repair:

Professional Licenses, Certifications or Registrations: _____

Do you have a CPR / First Aid Certificate Yes No

Additional skills including supervision skills, other languages, or information regarding the career/occupation you wish to bring to the employer's attention: _____

Information to the applicant: As part of our procedure for processing your employment application, your personal and employment references may be checked. If you have misrepresented or omitted any facts on this application, and are subsequently hired, you may be discharged from your job. You may make a written request for information derived from the checking of your references.

If necessary for and during employment, you may be required to: supply your birth certificate or other proof of authorization to work in the US, have a physical examination and/or a drug test, or to sign a conflict of interest agreement and abide by its terms.

Employment at Cornerstone Home Care is on an "at-will" basis and is for no definite period and may regardless of the date or method of payment of wages or salary, be terminated at any time with or without cause. Other than the Board of Directors of Cornerstone Home Care, no supervisor, manager or other person, irrespective of title or position, has authority to alter the at-will status of your employment or to enter into any employment contract for a definite period of time with you. Any agreement with you altering your at-will employment status must be in writing and signed by the Board of Directors.

I understand and agree to the information shown above:

Signature: _____ Date: _____

Equal Employment Opportunity: While many employers are required by federal law to have an Affirmative Action Program, all employers are required to provide equal employment opportunity and may ask your national origin, race and sex for planning and reporting purposes only. This information is optional and failure to provide it will have no affect on your application for employment.

Employer Section:



Department of Health and Social Services

DIVISION OF HEALTH CARE SERVICES
Background Check Program

4601 Business Park Blvd., Bldg K
Anchorage, Alaska 99503-7167
Main: 907.334.4475
Fax: 907.269.3488

Alaska Background Check Application

*Asterisks mark required fields. Applications will not be processed without complete information.

Personal Information

Full Legal Name: Last First M.I. Date of Birth (mm/dd/yyyy)

Permanent/ Physical Address: Physical Street Address Apartment/Unit # City State ZIP Code

Mailing Address (if different than Permanent/ Physical Address): Mailing Address Apartment/Unit # City State ZIP Code

Primary Phone: Secondary Phone:

*Applicant's Email Address:

*SSN (or ITN): This is an ITN

Demographic Information

*Race: (Asian, Black, White Native American, or Unknown) *Gender: (Male, Female, Unknown, Other) *Eye Color: (Black, Blue, Brown, Hazel, Green, Grey, Unknown) *Hair Color: (Black Blonde, Brown, Grey, Sandy or Light Brown, Red, White, Unknown) *Height: FT IN *Weight: Lbs. *Place of Birth (Country/State): US Citizen(Y/N):

Alias

Aliases/Prior Names (includes all names by which a person is currently known as, or has previously gone by, including nick names): Please attach additional pages as necessary

First Name: Middle Name: Last Name: SSN/ITN: Date of Birth: This is an ITN

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Prior Address History

Prior Addresses in the last 10 years: Please list the state(s) in which you have lived outside of Alaska for the last 10 years. This includes those states in which you have lived for schooling or training even if you remained an Alaska resident during that time. If you have lived in Alaska for the entirety of the last 10 years, you do not need to complete this section. Please attach additional pages as needed.

State: _____ Year(s) From: _____ to _____
State: _____ Year(s) From: _____ to _____
State: _____ Year(s) From: _____ to _____

Pre-Employment Information

Pre-Employment Information: Only complete this information if you are applying directly with a licensed and/or certified entity. The entity should provide you this information. If the entity does not provide this information to you, leave this section blank.

Provider Name: Comerstone Home Care

State Program under which the individual will work, such as Assisted Living, PCA, Hospital, Hospice, etc.: PCA

Position Title: Personal Care Worker

Position Type: Employee
(Employee/Independent Contractor/Volunteer/Other)

Instructions

1. You should only submit this form to the Background Check Program (BCP) if you have not already applied on-line or through a licensed and/or certified entity. You may apply on line at: <https://nabcs.dhss.ak.local/bcpapplicant>. Hard copy applications will only be processed in the order in which they are received and will not be processed until a full and complete application is received, including all applicable fees and fingerprint cards.
2. Hard copy applications submitted to the BCP will not be connected to any other application or to any specific provider type within the system and require fingerprint cards and all applicable fees. **Please note fees are non-refundable.**
3. Hard copy applications submitted to the BCP must be complete within 30 days from the date the application was received. All fees and fingerprint cards must be **received by** the BCP within the 30 day timeframe. Applications found incomplete after 30 days are automatically closed. If you still require a background check, you will be required to submit a new application including all fees and fingerprints.
4. Payments may be made by check, credit card or money order. Cash payments may only be made in person at 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503. All payments must be for the exact amount. If you wish to pay by credit card, you must contact the Background Check Program at (907) 334-4475 to make a payment over the phone. Fees for fingerprint based background checks are \$~~88.25~~ and are **not refundable.**
5. Please ensure you provide a valid email address. The email address will be used to communicate with you regarding your application status, including information regarding determinations or needed information.
6. If an eligible determination is made, you must associate with a licensed and/or certified entity within 100 days of the determination. Unassociated applications will be closed after 100 days without further notice and will immediately render a background check invalid. If you continue to need a valid criminal history check, you will be required to submit a new application including all fees and fingerprints.
7. A complete application includes this application form, non-refundable payment in the amount of \$~~88.25~~ and one set of fingerprints. Complete applications should be mailed to: State of Alaska, Background Check Program, 4601 Business Park Blvd., Bldg. K, Anchorage, AK 99503.

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, 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 through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, _____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

Applicant Signature

Date



RELEASE OF INFORMATION AUTHORIZATION FOR BACKGROUND CHECK

I, _____, authorize and consent to any person provided a copy or facsimile of this Release of Information Authorization for Background Check by an authorized representative of the Department of Health & Social Services, to disclose any information regarding me in relation to civil court information, criminal justice, juvenile justice, 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 through this Release of Information Authorization for Background Check will be held in confidence in accordance with DHSS guidelines.

I, _____, authorize and consent to the department marking my name in the Alaska Public Safety Information Network (APSIN) under 7 AAC 10.915(e).

This form must be signed; if the individual is 16-17 years of age, a parent signature must also be included.

Applicant Printed Name

Date

Applicant Signature

Applicant SSN

Parent Printed Name, if applicable

Parent Signature



CORNERSTONE HOME CARE

8800 Glacier Hwy., Suite 111 Juneau, AK 99801

Phone: (907) 586-6838 Fax: (907) 586-8114

Payroll Deduction Agreement

I, _____ (employee name) authorize my employer,

Cornerstone Home Care, to deduct \$88.25 from my paycheck to reimburse the agency

for the cost of my fingerprint background check required by the State.

This deduction will occur over:

CHECK ONLY ONE

The next pay period for the total amount of \$88.25.

OR

The next two pay periods in the amount of \$44.12 and \$44.13 per pay period.

I understand that if my employment ends before the total amount is paid in full, the remaining amount will be taken out of my last paycheck.

Employee Signature

Date

For Office Use Only:

Information sent to Payroll

Initials: