Background Check & CNA Registry Check Authorization

Potential Self Direct Employers must authorize SeniorsPlus to check the CNA Registry and complete a criminal background check.

As a potential Self Direct Employer through SeniorsPlus, I understand that a criminal background check and a CNA Registry check will be conducted. The information below is correct to the best of my knowledge.

Last Name: _____

First Name: _____

Middle Name: _____

Maiden Name or Alias (if applicable): _____

Date of Birth: _____ **Phone number:** _____

Gender: M ☐ F ☐

Address: _____

Potential Employer's Signature: _____

Date: _____

Please mail, fax, or email the completed from to:

Skills Trainer Coordinator
SeniorsPlus
8 Falcon Road
Lewiston, ME 04240

Email: skillstrainer@seniorsplus.org
Fax: 207-795-4009

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND CERTIFICATION

Family Provider Service Option

For the provision of home care services, not requiring licensed personnel.

SECTION 1: Provider Information			
Individual's Name:		MaineCare Number:	
Physical Address:			
City:	State:	Zip:	County:
Mailing Address (If Different)			
City:	State:	Zip:	County:
Telephone Number:		Email Address:	

SECTION 2: Fees

Registration Type:

☐ New Registration (fee $25) or;

☐ Annual Renewal Registration (fee $25)

Registration Renewal Period (dates):_____to _____

Total Fee Enclosed for application ..... $ 25.00

Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. Application fees are non-refundable.

Total Check/Money Order enclosed: $ = _____

SECTION 3: Family Service Provider Option

Please select all boxes that apply:

☐SeniorsPlus ☐Alpha One

☐I manage my own services. ☐I manage a family member's services:

1. Family member's name:_____Relationship: _____
2. Family member's name:_____Relationship: _____

SECTION 4: Declaration

- The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

_____ _____ _____

Print name of Provider **Signature of Provider** **Date**

Mail application to address below and for questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Certification – MFU
41 Anthony Avenue 11 State House Station
Augusta, ME 04333
Tel: (207) 287-9300 Toll Free: 1-800-791-4080 TTY users call Maine relay 711 Email:dlrs.info@maine.gov

Office Use Only:
*Check#*_____ *MO #*_____*Amount $*_____ *Initials:*_____ *License#* _____