**LEVEL 2 BACKGROUND SCREENING AND MEDICAID ENROLLMENT**

This information will allow us to search for a current background screening or initiate a new screening. If we need to initiate a screening, you will receive an email with instructions on the process.

• Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Any Former Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• State of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Eye Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Hair Color:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Sex:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer the following questions required for your Medicaid Enrollment Application. Has any individual ever:**

1) Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony?

☐ NO ☐Yes If yes, please submit supporting documentation.

2) Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state?

☐ NO ☐Yes

**If yes, against who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Please submit supporting documentation if yes.**

3) Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has?

☐ NO ☐Yes

**If yes, please submit supporting documentation**.

4) Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments?

☐ NO ☐Yes

**If yes, please submit supporting documentation.**

5) Owes money to Medicaid or Medicare that has not been paid?

☐ NO ☐Yes

**If yes, please submit supporting documentation.**

6) Have ownership in any other Medicaid enrolled business?

☐ NO ☐Yes

**If yes, please submit supporting documentation.**

**Name of Other Business:**

**Provider Number:**

**Name of Owner:**

I attest that all the above information is true and complete.

Contractor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contractor Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_