



**AMAZING OPPORTUNITIES
KENTUCKY**

Thank you for your interest in applying with Amazing Opportunities Kentucky! In addition to filling out the attached information, please provide the following documentation to ensure a timely review of your application:

- Copy of your current Driver's License
- Copy of your Social Security Card
- Copy of your current auto insurance
- Copy of CPR Certification (if you currently have it)
- If you have experience working with people with Intellectual and Developmental Disabilities, a copy of your resume.
- If you are under 21, copy of your High School Transcript/GED
- The last three pages are for YOU to keep

If you have any questions, you can email us at admin@aoky.org or call 606-207-0225 OR 606-484-0780



EMPLOYMENT APPLICATION

PERSONAL INFORMATION

LEGAL NAME: _____ **DOB:** _____
First Middle Last

PREFERRED NAME: _____ **MAIDEN:** _____
First Middle Last

PRONOUNS: SHE/HER HE/HIM THEY/THEIR OTHER: _____

ADDRESS: _____
Street Address Apt/Suite

City State Zip Code

HAVE YOU WORKED OR LIVED OUTSIDE OF KENTUCKY IN THE LAST YEAR? YES NO

E-MAIL: _____ **PHONE:** _____

SOCIAL SECURITY NUMBER (SSN): _____ - _____ - _____ **DL #:** _____

EMPLOYMENT ELIGIBILITY

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE U.S.? YES NO

HAVE YOU EVER WORKED FOR THIS EMPLOYER? YES NO

IF YES, WRITE THE START AND END DATES: _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO

IF YES, PLEASE EXPLAIN: _____

IF REQUIRED TO TRANSPORT, CAN YOU PROVIDE PROOF OF AT LEAST LIABILITY INSURANCE? YES NO

EDUCATION

HIGH SCHOOL: _____ **CITY / STATE:** _____

FROM: _____ **TO:** _____ **GRADUATE?** YES NO

COLLEGE: _____ **CITY / STATE:** _____

FROM: _____ **TO:** _____ **GRADUATE?** YES NO

DEGREE: _____

OTHER: _____ **CITY / STATE:** _____

FROM: _____ **TO:** _____ **DEGREE/CERTIFICATION:** _____

WORK EXPERIENCE

DO YOU HAVE PREVIOUS EXPERIENCE PROVIDING SERVICES TO INDIVIDUALS WITH DISABILITIES? YES NO

IF YES PLEASE EXPLAIN: _____

ARE YOU CURRENTLY EMPLOYED? YES NO

CURRENT EMPLOYER: _____
Company / Individual Supervisor Name Telephone Number

Street Address Apt/Suite City, State, Zip Code

Start Date Schedule (Days & Hours Working)

PLEASE LIST LAST FIVE YEARS OF EMPLOYMENT HISTORY

EMPLOYER 1: _____
Company / Individual Supervisors Name Telephone Number

Street Address Apt/Suite City, State, Zip Code

Job Title Job Duties

Start Date End Date Reason For Leaving

EMPLOYER 2: _____
Company / Individual

Street Address Apt/Suite City, State, Zip Code

Job Title Job Duties

Start Date End Date Reason For Leaving

EMPLOYER 3: _____
Company / Individual

Street Address Apt/Suite City, State, Zip Code

Job Title Job Duties

Start Date End Date Reason For Leaving

REFERENCES

FULL NAME: _____ RELATIONSHIP: _____
First Last

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

E-MAIL: _____ PHONE: _____

MILITARY SERVICE

ARE YOU A VETERAN? YES NO

BRANCH: _____ RANK AT DISCHARGE: _____

FROM: _____ TO: _____ TYPE OF DISCHARGE: _____

IF NOT HONORABLE, PLEASE EXPLAIN: _____

VOLUNTARY SELF-IDENTIFICATION DISABILITY DISCLOSURE

DO YOU HAVE A DISABILITY YES NO I DO NOT WISH TO ANSWER

BACKGROUND CHECK CONSENT

ARE YOU WILLING TO CONSENT TO A BACKGROUND CHECK? YES NO

ARE YOU WILLING TO CONSENT TO A DRUG TEST? YES NO

DISCLAIMER

As an equal opportunity employer Amazing Opportunities Kentucky stays true to our mission to help everyone live a life THEY want to live, including our employees. ALL applicants will receive consideration for employment without regard to sex, gender identity, sexual orientation, race, color, religion, national origin, disability, protected Veteran status, age, or any other characteristic protected by applicable law.

Please complete each section EVEN IF you decide to attach a resume.

_____ I, the applicant understand that I shall not be approved to work for this agency if results from my background check reveal that I have pled guilty to or been convicted of committing an offense as outlined in (SCL) 907 KAR 12:010, Section 3 (3), or (MPW) 907 KAR 1:835, Section 7. I understand that I shall not be approved to work for this agency if I am registered on the Kentucky Nurse Aide Abuse registry, or if I have been substantiated for abuse through the Central Registry Check. I understand that I shall not be approved to work with this agency if I am registered on the Adult Caregiver Misconduct Registry.

_____ I, the applicant understand that I shall not be approved to work for this agency if results from my drug screening reveal a positive drug test as outlined in 907 KAR 12:010

_____ I, the applicant understand that any offer of employment shall be subject to reference checks and drug/alcohol testing.

By signing below, I, the Applicant, certify that my answers are true and honest to the best of my knowledge. I give my consent for this agency to complete the necessary background checks listed above. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

SIGNATURE _____ **DATE** _____

PRINT NAME _____

AMAZING OPPORTUNITES OFFICIAL USE ONLY

The following background checks have been sufficiently reviewed:

- | | |
|---|----------------------|
| <input type="checkbox"/> AOC | Date Reviewed: _____ |
| <input type="checkbox"/> Kentucky Nurse Aide Abuse Registry | Date Reviewed: _____ |
| <input type="checkbox"/> Adult Caregiver Misconduct Registry | Date Reviewed: _____ |
| <input type="checkbox"/> Central Registry Check | Date Reviewed: _____ |

Alcohol/Drug Testing Results _____ Date Taken: _____

- Positive**
- Negative**

**Amazing Opportunities Kentucky
Admin Signature**

Date

DISCLOSURES TO BE PROVIDED TO AND SIGNED BY APPLICANT FOR EMPLOYMENT OR LICENSURE

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

FOR THIS TYPE OF EMPLOYMENT OR LICENSURE, STATE AND FEDERAL LAW REQUIRE A STATE AND NATIONAL CRIMINAL BACKGROUND CHECK AS A CONDITION OF EMPLOYMENT

By signing this notice of required disclosures, the applicant for employment, volunteer services, or professional licensure, has the responsibility to be aware of the following:

(1) A set of the applicant's fingerprints will be required to complete a background check under the Kentucky National Background Check Program (KY-NBCP).

(2) The applicant must complete and sign the Waiver Agreement and Statement (OIG 1:190-2), and provide a government-issued form of identification containing the applicant's photograph (such as a valid driver's license).

(3) A background check facilitated by the KY-NBCP shall include a:

(a) Check of required abuse registries;

(b) Check of licensing board data, if applicable, to validate licensure status; and

(c) Fingerprint-supported state and Federal Bureau of Investigation (FBI) criminal background check, which includes a comparison of the applicant's fingerprints with any latent fingerprints that may be on file with the Department of Kentucky State Police (KSP) or the FBI. The fingerprint images will be used for all criminal justice purposes.

(4) The applicant's fingerprint images and associated information will be retained by KSP and the FBI in their databases and will be used to determine if the applicant has any criminal history information on file with the State and Federal criminal history repositories. KSP or the FBI will process future searches, including latent fingerprint searches, against the applicant's fingerprints and make full use of them in any criminal prosecution under state or federal law, as well as notify the Cabinet for Health and Family Services of subsequent arrests and convictions indicated in the criminal history repositories concerning the applicant.

(5) Upon submission by the applicant to the fingerprint-supported State and FBI criminal background check, an employer *may* choose to hire the applicant provisionally while the background check is processed. Upon completion of the criminal background check, the Cabinet for Health and Family Services, Office of Inspector General may release any record of State criminal history found in the files of the Kentucky centralized criminal history record information system to the applicant's current or prospective employer as reported on the OIG 1:190-2, Waiver Agreement and Statement.

(6) The applicant's Social Security Account Number is needed in order to keep records accurate pursuant to the Federal Privacy Act Statement, which may be downloaded at: <http://www.fbi.gov/about-us/cjis/cc/library/privacy-act-statement-1>

(7) All information provided to the KY-NBCP, Office of Inspector General, Cabinet for Health and Family Services shall be kept confidential in compliance with applicable state and federal laws and regulations.

(8) The applicant has the right to request and inspect his or her criminal history record and to request correction of any inaccurate information. If the applicant does not exercise his or her right to inspect criminal history information, the Commonwealth shall not be responsible for the dissemination of inaccurate information, or liable for damages resulting from its determination of the applicant's eligibility for employment.

I HAVE READ, AND UNDERSTAND, THE FOREGOING DISCLOSURES.

Printed Name of Applicant: _____

Date of Birth: _____ Last Four Digits of SSN: _____

Signature: _____ Date: _____

Kentucky National Background Check Program (KY-NBCP)
Office of Inspector General, Cabinet for Health and Family Services

WAIVER AGREEMENT AND STATEMENT

Pursuant to the 906 KAR 1:190, Kentucky National Background Check Program, this form must be completed and signed by every prospective or current employee, volunteer, licensee, and contractor/vendor for whom fingerprint-based criminal history records are requested by a qualified entity.

I, the undersigned applicant, hereby authorize _____ (hereinafter "qualified entity") to request submission of a set of my fingerprints to the Department of Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) for the purpose of accessing and reviewing state and national criminal history records that may pertain to me. By signing this Waiver Agreement and Statement, it is my intent to authorize the dissemination of any Kentucky and national criminal history record that may pertain to me to the Kentucky Cabinet for Health and Family Services, Office of Inspector General (hereinafter "OIG") for the purpose of determining whether I am eligible for employment, licensing, serving as a volunteer, or working as a contractor/vendor under 906 KAR 1:190. I further authorize the OIG to release any record of State criminal history found in the files of the Kentucky centralized criminal history record information system to the above-named qualified entity. I understand that the OIG cannot disseminate any national criminal history record from the FBI to the above-named qualified entity pursuant to 28 C.F.R. 50.12.

I further understand that, until the criminal history background check is completed, the qualified entity may choose to hire me provisionally and deny me unsupervised access to children, the elderly, or individuals with disabilities. I understand that upon written request to the OIG, I will be provided with a copy, if any, of a KSP or FBI criminal history report received on me. I understand that the OIG will only provide my criminal history report by certified mail, restricted delivery service. To receive my criminal history report from the local post office, I understand that I must show proof of identity and provide my signature. I also understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before a final decision is made about my status as an employee, volunteer, or contractor/vendor. If I do not exercise my right to challenge the accuracy and completeness of any information contained in my criminal history report, I agree to hold harmless the KSP and its employees from any claim for damages arising from the dissemination of inaccurate information. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages as a result of actions taken in good faith to comply with 906 KAR 1:190, including the disqualification of an applicant or employee from employment on the basis of a disqualifying offense.

Yes, I have been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, or am under indictment for, a crime. **If yes, please describe the crime(s) and the particulars on an additional sheet of paper.**

No, I have not been convicted of, pled guilty to, entered an Alford plea or a plea of nolo contendere to, and am not under indictment for, a crime.

I am a current or prospective (check one): Employee Licensee Volunteer Contractor/Vendor

Applicant Signature: _____ **Date:** _____

Applicant Printed Name: _____

Applicant Date of Birth: _____ **Applicant Social Security Number:** _____

Applicant Address: _____

TO BE COMPLETED BY THE QUALIFIED ENTITY:

ENTITY NAME:	_____
ADDRESS:	_____
ENTITY ASSIGNED OCA:	_____

KEEP FOR YOUR RECORDS

Applicant Pre-Screening Form

(Please Type or Print Clearly)

The Applicant must provide this information before an application can be processed in the Kentucky Applicant Registry and Employment Screening (KARES) System

Declarations: By signing this form I consent to registry screening and submission of my fingerprints to the Kentucky State Police (KSP) for forwarding to the Federal Bureau of Investigation for the purpose of conducting a state and national criminal history records check pursuant to The Affordable Care Act¹ (ACA) Subtitle C, Section 6201 and pursuant to 906 KAR 1:190E. I understand that the results will be shared with the Kentucky National Background Check Program (KYNBCP) operated by the Cabinet for Health and Family Services – Office of Inspector General (CHFS-OIG).

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

I understand that as part of my application for employment or licensing, my fingerprints will be used to check the criminal history records of the Department of Kentucky State Police. I hereby give authority and consent to the Department of Kentucky State Police to retain my fingerprints and process future searches (including latent fingerprint searches) against them and make full use of them in any criminal prosecution under state or federal law. I also authorize and consent to the Department of Kentucky State Police notifying the Cabinet for Health and Family Services of subsequent arrests or convictions indicated in the criminal history records concerning me for use in determining my eligibility for employment or licensure. This authorization is given freely and voluntarily by me without coercion, duress, or threats of any kind.

Social Security Account Number (SSAN). Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

My signature acknowledges that I have read, understand and accept the terms and conditions outlined in this form.

Name of Facility or Employer:

Address of Employer:

Applicant's Last Name:

Applicants First and Middle Names:

Maiden Name:

Social Security Number:

Date of Birth:

Gender:

Government Issued ID (Include No. & Type):

State or Agency of Issue:

Race:

Eye Color:

Hair Color:

Height (feet & inches):

Weight (lbs):

U.S. Citizen (Yes/No):

Place of Birth:

Phone Number:

Phone Number Type:

Email Address:

Current Physical Address Line One:

Current Physical Address Line Two:

City:

State:

Zip Code:

County:

Current Mailing Address (if different):

City:

State:

Zip Code:

County:

Alt Phone Number:

Alt Phone Number Type:

List all residences you have lived at during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

Complete Address	Year From	Year To

List all cities and states where you have worked during the past seven years; include the timeframe in year from and year to format: (Use additional sheets if needed)

City	State	Year From	Year To

List any aliases and other names you have ever used; including any other dates of birth and social security numbers: (Use additional sheets if needed)

First Name	Middle Name	Last Name	Date of Birth	Social Security Number

Have you ever been convicted of a crime?

Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box for each conviction. Please provide the following: (1) offense(s) for which you were convicted; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Do you have any charges (pending) against you for a crime?

Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box for each charge. Please provide the following: (1) offense(s) for which you were charged; (2) the date of the conviction(s); (3) the state or territory where the conviction(s) occurred; (4) the court; and (5) any action(s) taken by the court against you, including any sentence, or probation imposed. (Use additional sheets if needed)

Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?

Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Has any government agency (other than the police) ever found that you abused an elderly person? Yes No

→ If you answered "YES" to the question above, please provide an explanation in this box, including when and where it happened.

Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes No

→ If yes, explain, including credential name, laminations or restrictions and time period.

Answering "NO" to all questions does not guarantee employment.

SIGNATURE, CERTIFICATION AND RELEASE OF INFORMATION

YOU MUST SIGN THIS FORM. Please read the following acknowledgements carefully before you sign.

I understand that information requested regarding gender, race, height, eye color, hair color, weight, place of birth, citizenship and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law.

I understand that a false statement on any part of this form is grounds for either not hiring me, or firing me after I begin work. I consent to the release of information regarding a criminal history on me by the Kentucky State Police, Federal Bureau of Investigation (FBI), and any of its authorized agents. I certify that, to the best of my knowledge and belief, all of my statements are true, correct and complete.

Applicant's Signature:	Signature of Parent or Guardian if Under Age 18:	
Signature of Authorized Personnel at Hiring Facility:	Title:	Today's Date:

Tuberculosis (TB) Risk Assessment

Name: _____ Cell# _____

Country of Origin: _____ Year arrived in US: _____

I. Screen for Active TB Symptoms (Check all that apply)

- None (Skip to Section II, "Screen for TB Infection Risk")
- Cough for ≥ 3 weeks → Productive: YES NO
- Hemoptysis
- Fever, unexplained
- Unexplained weight loss
- Poor appetite
- Night sweats
- Fatigue

Evaluate these symptoms in context

History of TB Skin Test / TB Treatment:

- History of positive TB Skin Test or clinical tuberculosis
- Date of positive TB Skin Test: _____
- Date of last Chest X Ray: _____
- is on immunosuppressive therapy (this includes treatment for Rheumatoid arthritis with drugs such as REMICADE, HUMIRA, etc.)

I Certify that this assessment contains no misrepresentation or falsification and the information given by me is true and complete to the best of my knowledge.

Signature

Date

II. Screen for TB Infection Risk (Check all that apply)

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI. The Patient:

- is a current high risk contact of a person known or suspected to have TB disease.
- has been in another country for - 3 or more months where TB is common, and has been in the US for ≤ 5 years
- is a resident or an employee of a high TB risk congregate setting
- is a healthcare worker who serves high-risk patients
- is medically underserved
- has been homeless within the past two years
- injects illicit drugs or uses crack cocaine
- is a member of a group identified by the health department to be at an increased risk for TB infection

B. Assess Risk for Developing TB Disease if Infected The Patient...

- is HIV positive
- was recently infected with *Mycobacterium tuberculosis*
- has certain clinical conditions, placing them at higher risk for TB disease: (Diabetes mellitus, silicosis, prolonged corticosteroid therapy etc.)
- injects illicit drugs
- has a history of inadequately treated TB
- is $>10\%$ below ideal body weight
- Chest x-ray findings that suggest previous TB
- Chest x-ray with fibrotic changes suggesting inactive or past TB
- Organ Transplant recipient

III. Finding(s) (Check all that apply)

- Previous Treatment for LTBI and/or TB disease
- No risk factors for TB infection
- Risk(s) for infection and/or progression to disease
- Possible TB suspect
- Previous (+) TST or (+) BAMT, no prior treatment

IV. Action(s) (Check all that apply)

- Issued screening letter
- Referred for Chest X-ray on _____
- Referred for medical evaluation on _____
- Other: _____

To be completed by a licensed medical professional:

Reviewers signature: _____

Reviewers name (print): _____

Reviewers title: _____

Date: _____ Phone #: _____

Comments: _____

Form Revised 8.22.23 by Kaitlyn Paschall, Program Director

Applicant and Employee Rights under Kentucky's National Background Check Program

An applicant or employee may: (1) challenge the accuracy and completeness of any information contained in his or her criminal history report, (2) challenge the finding that he or she is the true subject on an abuse registry, or (3) appeal the finding that he or she is not eligible for hire as the result of a State and FBI criminal history check in accordance with the following instructions:

I. Challenge Requests

Pursuant to Kentucky's Criminal History Record Information User Agreement, Section 6.12, a copy of an applicant's KSP and/or FBI rap sheet may be provided to the applicant upon completion of the initial fitness determination. A written request for the rap sheet must be submitted to the OIG at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Upon receipt of the request, the OIG will send a copy of the applicant's rap sheet by certified mail, restricted delivery service. Applicants must show proof of identity and sign for the certified mail to obtain his or her rap sheet from the local post office.

Request to Challenge a KSP rap sheet: If an applicant believes that the information contained in his or her KSP rap sheet is incomplete or inaccurate, the applicant may contact the Kentucky State Police, Criminal Records Dissemination Section, at (502) 227-8700.

Request to Challenge an FBI rap sheet: In accordance with 28 C.F.R. 16.34, if an applicant believes that any information contained in his or her FBI rap sheet is incomplete or inaccurate, the applicant may direct his/her challenge regarding the accuracy or completeness of any entry on his/her record to:

FBI, Criminal Justice Information Services (CJIS) Division
ATTN: SCU, Mod. D-2
1000 Custer Hollow Road
Clarksburg, WV 26306

Abuse Registries: If an applicant believes that his or her name is listed on one of the following abuse registries in error, the applicant may contact the agency responsible for the registry as follows:

- **List of Excluded Individuals/Entities (LEIE)** – Contact the federal DHHS Office of Inspector General
 - <http://oig.hhs.gov/contact-us/>
- **Kentucky Nurse Aide Abuse Registry** – Contact the Kentucky CHFS Office of Inspector General
 - (502) 564-7963
- **Kentucky Caregiver Misconduct Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497
- **Kentucky Child Abuse and Neglect Registry** - Contact the Kentucky CHFS Ombudsman Office
 - (800) 372-2973 or (502) 564-5497

Out-of-state abuse registry findings must be addressed with the agency responsible for maintaining the abuse record.

Professional Licensing: If an applicant believes that his or her professional license is incorrectly reported as “not in good standing” or otherwise inactive, the applicant may contact the appropriate professional licensing board.

II. Request for Informal Review

If an applicant wishes to challenge the accuracy of the OIG's determination that the applicant is "not eligible for hire" based on the results of the applicant's criminal history check, the applicant may request an informal review as follows:

Step One: The applicant must sign, date, and send a written request for an informal review no later than 10 calendar days from the date of notice of the disqualifying offense to the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

Step Two: The applicant's written request must include a copy of official documentation verifying the disqualifying offense was dismissed or otherwise removed from the applicant's criminal history report.

*See Request for Administrative Hearing if dissatisfied with outcome of the informal review.

III. Request for Rehabilitation Review

Certain criminal offenses found upon completion of a State and FBI criminal background check are eligible for consideration under the rehabilitation review process. The rehabilitation review process allows an applicant the opportunity to demonstrate that he or she is rehabilitated and not likely to repeat the conduct that led to the disqualifying offense.

Offenses not eligible for consideration under the rehabilitation review process include the following:

1. A disqualifying felony offense that occurred less than seven (7) years prior to the date of the criminal background check;
2. Any disqualifying felony or misdemeanor offense related to abuse, neglect, or exploitation of an adult defined by KRS 209.020(4) or a child;
3. A felony or misdemeanor sexual offense;
4. Registration as a sex offender under federal law or under the law of any state; or
5. Any person who is a violent offender.

A request for rehabilitation review shall be made as follows:

1. A written request must be signed, dated, and mailed to the National Background Check Program at the following address:

Attn: National Background Check Program
Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

2. Be mailed no later than 14 calendar days from the date of notice of the disqualifying offense; and
3. Be accompanied by a written explanation of each disqualifying criminal offense, including:
 - A description of the events related to the disqualifying offense;

- The number of years since the occurrence of the disqualifying offense;
- The age of the offender at the time of the disqualifying offense;
- Any other circumstances surrounding the offense;
- Official documentation showing that all fines, including court-imposed fines or restitution, have been paid or documentation showing adherence to a payment schedule, if applicable;
- The date probation or parole was satisfactorily completed, if applicable; and
- Employment and character references, including any other evidence demonstrating the ability of the individual to perform the employment responsibilities and duties competently.

*See Request for Administrative Hearing if dissatisfied with outcome of the rehabilitation review.

IV. Request for Administrative Hearing

An applicant may appeal the results of an informal review or rehabilitation review by submitting a written request for an administrative hearing to the Office of Ombudsman at the address provided below. The request must be submitted within 30 calendar days of notice of the decision from the informal review or rehabilitation review.

The request for an administrative hearing must be signed, dated, and mailed to the following address:

Attn: Office of Ombudsman
Cabinet for Health and Family Services
275 East Main Street, 1E-B
Frankfort, Kentucky 40621