


<p>NYS Department of Health</p>  <p style="text-align: right;">CHRC Unit P. O. Box 2607 Albany, NY 12220-0607 Phone: 518.402.5549 Fax: 518.474.7477</p> <p style="text-align: right;">www.nyhealth.gov/chrc chrc@health.state.ny.us</p>	<p>AUTHORIZED PERSON DESIGNATION FORM AND NOTARIZED SWORN STATEMENT PAGE 1</p> <p>CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM</p>	<p><i>For Department use only Leave blank</i></p>
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The purpose of this form is to designate the Authorized Person for your Agency that is allowed to request, on behalf of your Agency, fingerprints and criminal history record checks pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

For purposes of this form, the term “Agency” means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information. “Agency representative” shall mean a sole proprietor for a sole proprietorship, any authorized partner of a partnership, any authorized director or officer of a corporation and any authorized member or manager of a limited liability corporation (LLC). “Authorized Person” is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks. “Subject individual” is an “employee” as defined by Public Health Law Section 2899(3).

**Type or print all information – USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.**

INSTRUCTIONS:

1. Please complete all fields on this form. One form must be completed for each Authorized Person designated by the Agency.
2. **The Authorized Person must have a current Health Provider Network (HPN) account and be designated the “CHRC Authorized Person” in the HPN Communications Directory. Print or type the HPN User ID where indicated.**
3. The Authorized Person must sign and date this form where indicated; notarization is required.
4. This form and DOH CHRC 100 (Agency Request Form) must be forwarded to the DOH CHRC Unit at the address indicated above **BEFORE** submitting subject individual CHRC requests.

SECTION 1 – AGENCY REPRESENTATIVE APPROVAL


I hereby designate the individual identified in Section 2 to serve as the Authorized Person for the Agency as noted on this form.

Name: _____ Title: _____

Signature of Agency Representative: _____ Date: _____
(refer to definition of Agency representative shown above)

SECTION 2 – AUTHORIZED PERSON

Last Name	First Name	M.I.	Title
Work Email Address	Work Phone Number	HPN User ID (must have active account)	
Agency Name		Agency PFI number or LHCSA Operating License number	
Work Address (Street)			
City	State	Zip	

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SECTION 3 - AUTHORIZED PERSON SWORN STATEMENT

By submitting a request for a criminal history record review through the DOH Criminal History Record Check (CHRC) Program on behalf of the following Agency, I hereby attest to the following:

1. I am a duly Authorized Person, as defined in Section 845-b of the Executive Law, for the above-named agency. As such, I am authorized to request, receive, and review criminal history information for this agency in accordance with law.
2. Each application for a subject individual for whom a criminal history check has been submitted to DOH CHRC Unit will be authorized by me.
3. Each subject individual will be informed that the Agency identified above is authorized to request criminal history record checks and to review the results of such checks.
4. Each subject individual will be informed that he or she has the right to obtain, review and seek correction of his/her criminal history information pursuant to rules and regulations of the New York State Division of Criminal Justice Services and the FBI. The signed, informed consent of each subject individual will be obtained prior to requesting a criminal history record check.
5. The results of each criminal history record check generated as a result of the CHRC Program will be used by the above-named agency solely for the purposes authorized by law.
6. Upon information and belief, the above-named Agency, its agents, and employees are aware of and will abide by the confidentiality requirements and all other requirements pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 4 - AUTHORIZED PERSON SIGNATURE AND NOTARY ACKNOWLEDGMENT

I understand that my role in the Criminal History Record Check (CHRC) Program is granted for the sole purpose of performing responsibilities as the Authorized Person for this Agency related to the request, receipt and review of criminal history record checks pursuant to provisions of Article 28-E of the Public Health Law and Section 845-b of the Executive Law. I agree to use this application solely in support of that responsibility. I further understand that the results of the criminal history record checks will only be used and disseminated for purposes authorized by law, and I will abide by the confidentiality requirements set forth in law.

Agency Name		PFI or Operating License No	
Print Name of Authorized Person		Title	
Authorized Person Signature			

Acknowledgment to be completed by a Notary Public

State of _____

County of _____

On this _____ day of _____, 20____, before me personally appeared _____

Known to me to be the same person described in and who executed the foregoing instrument, and ___he duly acknowledged to me that ___he executed same.

Notary Public
(Please sign, affix stamp and include expiration date)

DOH USE ONLY

ENTERED: _____
Date By