

**REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING**

## Applicant Submission

1. ORI: <b>A0448</b>			
2. Working Title: <i>(Check ✓ one)</i> <input type="checkbox"/> Adult Resident other than Client <input type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer <input type="checkbox"/> Home Care Aide Registry Applicant			
3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type."			
4. Agency Address Set Contributing Agency: <b>CA Dept of Social Services</b> <span style="float: right;"><b>03502</b></span>			
Agency authorized to receive criminal history information		Mail Code <i>(five-digit code assigned by DOJ)</i>	
<b>PO BOX 94244</b>	<b>Mail Station 9-15-62</b>	<b>N/A</b>	
Street No.	Street or PO Box	Contact Name <i>(Mandatory for all school submissions)</i>	
<b>Sacramento,</b>	<b>CA</b>	<b>94244-2430</b>	(    ) <b>N/A</b>
City	State	Zip Code	Contact Telephone No.
5. Applicant Information:			
Name of Applicant: <i>(Please print)</i> _____		_____	
	LAST	FIRST	MI
AKA's: _____		CDL No. _____	
	LAST	FIRST	
DOB: _____		Misc. No. <b>BIL -</b>	
	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	<small>AGENCY BILLING NUMBER (IF APPLICABLE)</small>	
HT: _____		Misc. No.: _____	
WT: _____		<small>PERMANENT RESIDENT (I-551), OUT OF STATE DRIVER'S LICENSE OR I.D.</small>	
EYE Color: _____		Home Address: <i>(All applicants must complete)</i>	
HAIR Color: _____		_____	
POB: _____		<small>STREET OR PO BOX</small>	
SOC: _____		<small>CITY, STATE AND ZIP CODE</small>	
<small>(See Privacy Statement on Page 4)</small>			
6. Facility/Organization Number: _____ Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> FBI			
If resubmission for fingerprint quality (select R2), list Original ATI No. _____			
7. Employer: <i>(Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)</i>			
Employer Name _____			
Street No.		Street or PO Box	
_____		_____	
City		State	
_____		_____	
Zip Code		Mail Code <i>(five digit code assigned by DOJ)</i>	
_____		_____	
Agency Telephone No. <i>(Optional)</i>		_____	
8.			
Live Scan Transaction Completed By: _____		Date _____	
<small>Name of Operator</small>			
Transmitting Agency		Amount Collected/Billed	
_____		_____	
LSID#		ATI No.	
_____		_____	

**GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO  
USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING  
Instructions for the LIC 9163**

1. **Originating Response Indicator (ORI):** Preprinted
2. **Working Title:** Check the appropriate box
3. **Authorized Applicant Type:** Indicate the facility type where you will be working.

Select your licensed facility type from the left column, and in the right column find its corresponding DOJ abbreviated facility type. **Enter the corresponding DOJ abbreviated facility type on this line.**

**Note:** In the following table you may be able to identify yourself with more than one facility type within each category. Please select only one facility type in any category using the facility that you are most associated with on a day-to-day basis.

**If this is your applicable facility type      ⇒ Enter this abbreviated facility type on your application.**

<b>CCLD Facility Type by Category</b>	<b>DOJ Abbreviated CCLD Facility Type</b>
Home Care Aide	Home Care Aide
Home Care Organization	Home Care Organization
Adult Day Care Facility Adult Day Support Center Adult Residential Facility Social Rehabilitation Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Center more/6 Child
Family Child Care Home	Family Day Care
Foster Family Agency Foster Family / Adoptions Agency Foster Family Agency Sub Office	Foster Family/Adopt Employment
Foster Family Agency - Certified Home Foster Family Home	Foster Family Home
Group Home (6 or less children)	Group Home 6/child less
Group Home (7 or more) Community Treatment Facility	Group Home more/6 child
Residential Care Facility for the Chronically Ill Residential Care Facilities for the Elderly	Residential Care Facility Elderly
Small Family Home Transitional Housing Placement Program	Residential Child Care 6/less

**4. Agency Address Set Contributing Agency:**

**Agency authorized to receive criminal history information:**

**The following information is pre-printed:**

**Agency:** CA Dept of Social Services                      **Mail Code:** 03502

**Street No.:** P.O. BOX 94244, M.S. 9-15-62                      **Contact Name:** N/A

**City, State, Zip:** Sacramento, CA 94244-2430                      **Contact Telephone No.:** N/A

**5. Applicant Information:** Print your full name (last, first, middle initial).

**AKA's:** Other names the applicant has used

**CDL No:** CA Drivers License or CA ID

**DOB:** Date of Birth                      **SEX:** Male or Female

**MISC No: BIL -** Enter the agency billing number, if applicable

**HT:** Height

**WT:** Weight

**MISC No.:** Enter any other identification numbers  
(PERMANENT RESIDENT, OUT OF STATE DRIVER'S LICENSE OR I.D.)

**EYE Color:** Color of eyes

**HAIR Color:** Color of hair

**Home Address:** Applicant's home address

**POB:** State or Country of Birth

**SOC:** Social Security Number (optional) (See Privacy Statement on Page 4)

**6. Facility Number:** Enter the facility number or assigned OCA number (Agency Identifying Number).

**Level of Service:** **Preprinted**

**Note:** If a Child Abuse Central Index (CACI) check is required, it will automatically be completed by DOJ and all applicable fees will be charged. There is no entry necessary on the applicant's part.

**If resubmission for fingerprint quality, list Original Applicant Tracking Information (ATI) No.:** If your fingerprints were rejected and this is a resubmission of your prints, enter the original ATI number provided on the reject notice to avoid paying an additional processing fee.

**7. Employer:** Enter the facility name and address for which you are being printed.

**Employer Name:**

Enter the facility/organization name.

**Street No.:**

Enter the facility/organization address.

**Mail Code:**

Enter the facility/organization mail code (if applicable).

**City, State, Zip:**

Enter the facility/organization city, state and zip.

**Agency Telephone No.:**

Enter the facility/organization phone number.

**8. Live Scan Transaction Completed By:** This section will be completed by the Live Scan operator.

**Take two copies of this form with you the day you are fingerprinted. The Live Scan Operator will complete section 8. One copy will be retained by the Operator and the other you may retain for your records.**

## **PRIVACY STATEMENT**

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

### **NOTE: IMPORTANT INFORMATION**

The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.