



Background Information Questionnaire

NAME

First: _____ Full Middle: _____ Last: _____

Please list any prior names or aliases: _____

CONTACT INFORMATION

CURRENT

Address _____

City _____ State _____ Zip _____

Phone # _____ Email Address: _____

**** If you have lived OUTSIDE of MN within the past 5 years, please list that address below. ****

PREVIOUS

Address _____

City _____ State _____ Zip _____

*** Applicant resided at previous address from ____ / ____ / 20__ to ____ / ____ / 20__**

BACKGROUND INFORMATION

- **Form of Identification:** Please check the applicable box and provide a copy of the document.

Driver's License ☐ State-Issued ID ☐ Passport ☐ Permanent Resident Card ☐

ID # _____ Expiration: ____ / ____ / ____ Issuing State: _____

- Social Security #: _____ - _____ - _____ DOB: ____ / ____ / ____ Birth State: _____

- Are you a United States citizen? YES ☐ NO ☐

- **Physical Description:**

Height: _____ Eye color: _____ Sex: _____

Weight: _____ Hair color: _____ Race: _____

- Do you have any allergies to smoke, cats, dogs, peanuts, etc.? YES ☐ NO ☐

If YES, please specify allergies. _____

Please return this fully completed document via email to connect@carepointhomehealth.com or fax to 651.998.2400. Thank you!

OFFICE USE ONLY:

PCA Certificate#: _____ Date Passed: _____

BGS Application # _____ Background Study # _____