Vaya Health

Authorization, Consent and Release

to Perform Criminal Background and Exclusion Checks pursuant to the Fair Credit Reporting Act (FCRA) and the Federal Driver's Privacy Protection Act (DPPA)

This form must be completed by every practitioner, owner and managing employee identified on the Credentialing Initation Application.

Name of agency, group practice, facility or hospital submitting application: _____

Last name: _____ **First name:** _____ **Middle initial:** _____

Maiden and/or other last names used: _____ **Gender:** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender

Driver's license no.: _____ **State issued:** _____ **Expiration date:** _____

Date of birth: _____ **Social Security Number:** _____

Please list all counties and states where you have resided for the past five years:

County and state:	From month/year:	To month/year:

By signing below, I authorize Vaya Health ("Vaya"), its staff, authorized representatives and/or its agent, Accurate Background, to conduct background investigations as part of an application for credentialing or re-credentialing submitted by the organization listed above, whether the records are of a public, private or confidential nature. These investigations are limited to searches of motor vehicle records and criminal history information on file in local, state or federal agencies; searches of local, state or federal records necessary for participation in public healthcare programs, including, but not limited to, the U.S. Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), the System of Award Management (SAM), the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System; and verification of education, employment history and professional liability/licensure history as applicable. Vaya does not perform searches of commercial or retail credit agencies.

I understand that these searches will be used to determine eligibility for credentialing and participation in the Vaya Closed Network, that information obtained pursuant to this authorization is confidential and that disclosure of this information will be limited only to those persons or entities to whom such disclosure is necessary or authorized for purposes of credentialing verification. Therefore, I authorize and consent for full release of records (either orally or in writing) to Vaya, its staff, authorized representatives and/or its agent, Accurate Background. In addition, I release and discharge Vaya, its staff, authorized representatives and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that according to the federal Fair Credit Reporting Act, I am entitled to know whether credentialing was denied based upon the information obtained and to receive, upon written request, a copy of the background report. After reading this document, I fully understand its contents and authorize the background investigation. This authorization shall expire one (1) year from the date signed below, or, if the applicant is approved for participation in the Vaya Health Provider Network, upon termination of such participation.

I hereby certify that all information provided in this authorization and release is true, correct and complete.

Signed this _____ day of _____, 20_____

Applicant (print name): _____

Applicant signature: _____