

**NOTICE OF FORM CHANGE NO. 05-055**

DATE

04/15/2005

**TO:**  
County Welfare Director  
Supply Clerk / Forms Coordinator

**FROM:**  
Forms Management Unit  
(916) 657-1907

Community Care Licensing District Offices  
 Private and Public Adoption Agencies

District Attorney  
 Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE LIC 9163 (4/05) - Request For Live Scan Service

ORDER UNIT <b>MASTER ONLY</b>	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 4/05	REPLACES 4/02	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> Other:	

**FORMS DISPOSITION AND SPECIAL INSTRUCTIONS**

DISPOSITION OF OLD SUPPLY

Use until exhausted  Destroy

USE NEW FORM

When supply available in DSS Warehouse  Use new form effective \_\_\_\_\_

USE FORM IN ACCORDANCE WITH

All County Letter No.  
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Form is a Master Only

Attached is a Reproducible Copy

Check on the internet to see if forms are available at [www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: [fmudss@dss.ca.gov](mailto:fmudss@dss.ca.gov). Contact Language Services for other languages at (916) 445-6778 or by electronic mail at [LTS@dss.ca.gov](mailto:LTS@dss.ca.gov).

# REQUEST FOR LIVE SCAN SERVICE

## Applicant Submission

1. ORI: (Check <input checked="" type="checkbox"/> one) Code assigned by DOJ			
		<input type="checkbox"/> CCLD A0448	<input type="checkbox"/> Trustline A1157
2. Type of Application: (Check <input checked="" type="checkbox"/> one)			
		<input type="checkbox"/> Employment	<input type="checkbox"/> License, Certification, Permit <input type="checkbox"/> Volunteer
3. Job Title or Type of License, Certification or Permit:			
4. Agency Address Set Contributing Agency:			
<b>CA Dept of Social Services</b>		<b>03502</b>	
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)	
<b>PO BOX 944243</b>		<b>N/A</b>	
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)	
<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: (Please print) _____			
		LAST	FIRST MI
AKA's: _____		CDL No. _____	
		LAST	FIRST
DOB: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female		Misc. No. <b>BIL -</b>	
		AGENCY BILLING NUMBER (IF APPLICABLE)	
HT: _____ WT: _____		Misc. No.: _____	
		ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.	
EYE Color: _____ HAIR Color: _____		Home Address: (All applicants must complete)	
POB: _____		_____	
		STREET OR PO BOX	
SOC: _____		_____	
		CITY, STATE AND ZIP CODE	
6. Facility Number: _____			
		Level of Service <input type="checkbox"/> DOJ <input type="checkbox"/> FBI	
If resubmission (select R2), list Original ATI No. _____			
7. <b>NOTE: NOT APPLICABLE FOR TRUSTLINE APPLICANTS</b>			
Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)			
Employer Name _____			
Street No.		Street or PO Box	
		Mail Code (five digit code assigned by DOJ)	
City	State	Zip Code	Agency Telephone No. (Optional)
8.			
Live Scan Transaction Completed By: _____			Date _____
			Name of Operator
Transmitting Agency	LSID#	ATI No.	Amount Collected/Billed

**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):** Enter the CCLD or TrustLine ORI code below that pertains to you. Select one of the following:  
     For CCLD applicants, **check:**           **A0448**  
     For TrustLine applicants, **check:**       **A1157**
- 2 Type of Application:** Check the appropriate box.
- 3 Job Title or Type of License, Certification or Permit:** Indicate the facility type where you will be working.

**For Applicants using a CCLD Live Scan Site:**

Select your CCLD facility type from the left column in the table below. **Enter this facility type on this line.**

**For Applicants using a Department of Justice (DOJ) Live Scan Site (Law enforcement office):**

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>
Adult Day Care Facility Adult Day Support Center Adult Residential Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Cent 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 Emp.
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	Residentl Care Fac Elderly
Small Family Home Transitional Housing Placement Program	Resid Child Care 6 / less
Social Rehabilitation Facility	Adult Day / Resident / Rehab
TrustLine (Voluntary) TrustLine (Subsidized)	<b>TrustLine subsidized applicants cannot currently go to non-CCLD Live Scan sites</b>

**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 944243, M.S. 19-62                      **Contact Name:** N/A

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

**5 Name of Applicant:** Enter 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 associated licensed facility numbers.  
(ALIEN REGISTRATION, 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)

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

**Level of Service:**

Check the DOJ box for a California criminal background check. Check the FBI box for a nationwide background check. **Note: If a Child Abuse Central Index check (CACI) 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, 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 (you may place a pre-printed mailing label in this area).

**NOTE:** This section not applicable to TrustLine applicants.

**Employer Name:**

Enter the facility name.

**Street No.:**

Enter the facility address.

**Mail Code:**

Enter the facility mail code (if applicable).

**City, State, Zip:**

Enter the facility city, state and zip.

**Agency Telephone No.:**

Enter the facility phone number.

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

**It is important that you bring this form with you the day you are fingerprinted to have the Live Scan Operator complete section 8. Please keep a copy for your records. This may serve as a receipt for payment of Live Scan services and may be required to accompany the care provider application.**