



**Authorization and Release for Protective Services
Record Checks for Providers and
Agency Personnel for Employment Purposes**

Please complete and sign below. The form must be legible, and all fields must be **filled out COMPLETELY**.

Name (Print full name. Do not use initials): _____
(First Name) (Middle Name) (Last Name)

Birth Date: _____ Social Security Number: _____

Current Home Address (Give location address, as well as P.O. Box address and County):

Please list all addresses or the county(s) and state(s) of all previous residences:

List maiden name, all aliases, or names known by Print full name(s); do not use initials:

Name of Agency who will receive results/verification of the protective services check:

Agency Address: _____

Agency Contact Information: _____

Type of Agency:

- Child Placing Agency (Potential employee)
- Residential Provider Agency (Including Psychiatric Residential (PRTF)/Intermediate Care Facilities (ICF))
- Emergency Shelter
- Child Care/Head Start
- Other _____

Certification:

Bureau for Social Services, 350 Capitol Street, B-18, Charleston, WV 25301

I certify that I have not committed any act of child/adult abuse or neglect, as determined by a civil or criminal proceeding or through an investigation by the WV Department of Health and Human Resources or through any like agency of any other state or country, or that I am currently being investigated for such except as stated below:

Authorization:

I authorize the WV Department of Health and Human Resources to conduct a background check on me which includes a search of Child Protective Services records, Adult Protective Services records, Youth Services records, Institutional Investigation Unit records and foster care provider records maintained by the Department. I authorize the Department to inform the person or agency named on the front of this form of the results of the background check, including any history I have had with Social Services. I understand that if I have an open CPS/APS investigation the protective service check will not be completed; the open investigation will be documented on the form and returned to the requesting agency. **I understand that a positive history of maltreatment in any West Virginia Department of Health and Human Resources protective services record will affect my becoming a foster care placement provider or employee of an agency that provides foster care services. I understand that any involvement I have had with the WVDHHR as a client or foster care provider will be evaluated and may also affect my becoming a foster care placement provider or foster care agency employee.** I release the WVDHHR and/or its agents in providing information pursuant to this authorization from any and all liabilities, claims or lawsuits.

Signature: _____ **Date:** _____

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- No record of substantiated maltreatment was found.
- Records indicate that maltreatment occurred by the individual.
- Records indicate current open CPS, and/or APS investigation.

IF THIS CLIENT HAS ANY QUESTIONS OR NEEDS TO OBTAIN INVESTIGATION RECORDS, THEY MUST CONTACT THE FOLLOWING COUNTY:

COUNTY: _____

INTAKE/CASE #: _____

(DHHR Stamp or Signature of Authorized Individual)

(Date)