Authorization and Release for Protective Services and Provider Record Checks for Adoption/Foster Care Only

Bureau for Children and Families
350 Capitol Street, Room 691
Charleston, WV 25301

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

Name (Print your 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):

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If you have not lived at your current address for 5 years, please list the address(es) for your location(s) in the last 5 years: ____

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____

List maiden name, all aliases, or names known by (Print your full name. Do not use initials):

____

____

Agency Name: ____
(who needs to receive verification of the protective service check)

Agency Address: ____

Agency Phone Number: ____

Type of Agency:
___ Child Placing Foster Care Agency
___ Adoption Agency
___ DHHR (Foster Family Home/Certified Kinship Home)

Certification:
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**:**

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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, 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 a positive history of maltreatment in any West Virginia Department of Health and Human Resources protective services record will affect my becoming a kinship, foster or adoptive parent. 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 kinship, foster or adoptive parent.** I release the WVDHHR and/or its agents in providing information pursuant to this authorization from any and all liabilities, claims or lawsuits.

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(Signature) **(Date)**

DHHR Office Use Only

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___________**No record of substantiated maltreatment was found**

___________ **Records indicate that maltreatment occurred by the individual.**

___________**Records indicate prior or current IIU investigations.**

___________**Records indicate involvement in a current or past youth services, CPS and/or APS case as an adult.**

___________**Records indicate a past or current foster care provider record for this individual.**

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

COUNTY: ____

INTAKE/CASE #: ____

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(DHHR Stamp or Signature of Authorized Individual) (Date)