WEST VIRGINIA Department of Health & Human Resources

AUTHORIZATION and RELEASE for PROTECTIVE SERVICES RECORD CHECK

West Virginia Nonresident 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):

_____
_____

Your West Virginia address:

_____
_____
_____

List maiden name (s), and 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: _____

Agency Type:
_____ Child Care/Head Start
_____ Residential Facility Staff
_____ Other (home health, homemaker services, etc.)

You are completing this form because you are a (check which applies):

_____ Volunteer _____Employee _____Owner/Director
_____ Household Member of an Adult or Child Care setting

CERTIFICATION:

I certify that have not committed any act of child or 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, and Institutional Investigation Unit 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. **I understand that a positive history of maltreatment in any West Virginia Department of Health and Human Resources protective services record will affect my working in a child care, foster care, or adult care setting**. 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)**

DHHR OFFICE USE ONLY

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_____ No record of substantiated maltreatment was found

_____ Records indicate that maltreatment occurred by the individual

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

COUNTY: _____

INTAKE#: _____

_____ _____

(DHHR Stamp or Initials of Authorized Individual) **(Date)**