



AUTHORIZATION and RELEASE for PROTECTIVE SERVICES RECORD CHECK

Bureau for Children and Families
350 Capitol Street, B-18
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):

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: _____

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)