WEST VIRGINIA Department of Health & Human Resources

Authorization and Release for Protective Services and Provider Record Checks for All Resource/Foster and Kinship/Relative Providers

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

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 (Including resource/foster care providers)**
- ☐ **DHHR (Resource Family Home/Certified Kinship/Relative Home)**
- ☐ **Specialized Family Care Agency (Medley)**

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 West Virginia Department of Health and Human Resources (DHHR) 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 DHHR 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 DHHR 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 note 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 DHHR protective services record will affect my becoming a resource/foster care placement provider. I understand that any involvement I have had with DHHR as a client or foster care provider will be evaluated and may also affect my becoming a foster care placement provider.** I release DHHR 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

- ☐ **No record of substantiated maltreatment was found.**
- ☐ **Records indicate that maltreatment occurred by the individual.**
- ☐ **Records indicate current open CPS, and/or APS investigation.**
- ☐ **Records indicate prior or current IIU investigation(s).**
- ☐ **Records indicate involvement in current or past youth service, 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 #: _____

_____

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