AUTHORIZATION and RELEASE for PROTECTIVE SERVICES RECORD CHECK

West Virginia Nonresident ONLY

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):

_____

_____

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

……

_____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)**