WEST VIRGINIA Department of Health & Human Resources

AUTHORIZATION and RELEASE for PROTECTIVE SERVICES RECORD CHECK

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

Please complete the following and sign below. All applicants to operate a home, program or facility for the care of children or adults and the adult family members, staff or adult volunteers of such home, program or facility are to complete this form.

Please use BLUE INK.

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):

_____

_____

_____

The name, address and telephone number of the agency which needs to receive verification of the protective services record check:

KANAWHA VALLEY SENIOR SERVICES INC

2428 KANAWHA BLVD EAST CHARLESTON WV 25311 OFFICE:304 348-0707

FAX: 304 344-3546

Type of Agency you are completing this form for:

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

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

_____ Volunteer ___X___ 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, neglect or maltreatment, 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 PLEASE CONTACT THE FOLLOWING COUNTY:

COUNTY: _____

INTAKE#: _____

_____ _____

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