RC Initials: ______________
Program: ADW I/DD TBI
Current EE: Yes No

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, 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:

Public Partnerships, LLC 200 Association Drive, Suite 130, Charleston, WV 25311 (304) 988-4200

____

Type of Agency you are completing this form for:

- ☐ **Child Care/Head Start**
- ☐ **Residential Facility**
- ☒ **Other (home health, homemaker services, etc.):** Self-Directed Employee – WV Program

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 or Foster Home**

(Over)

Certification:

I certify that I 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 effect 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 Signature of Authorized Individual) (Date)