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

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**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:** William R. Sharpe, Jr. Hospital
**(who needs to receive verification of the protective service check)**

**Agency Address:** 936 Sharpe Hospital Rd. Weston, WV 26452

**Agency Phone Number:** 304-269-1210

**Agency Type:**

_____ **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 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**

_____ **Records indicate involvement in a current or past youth services, CPS and/or APS case as an adult.**

**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)**