



# Authorization and Release for Protective Services Record Check

Bureau for Children and Families  
350 Capitol Street  
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. Applicants for adoption must also complete this form.

**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:**  
\_\_\_\_\_  
\_\_\_\_\_

**Type of Agency you are completing this form for:**  
 Child Placing Agency/Foster Family Home  
 Child Care/Head Start  
 Foster Care/Residential Facility  
 States and agencies as required by the Adam Walsh Child Protection and Safety Act of 2006  
 Other, Specify \_\_\_\_\_

**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  
 Applicant to adopt a child(ren)

**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:

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**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.

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(Signature) (Date)

**DHHR Office Use Only**

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\_\_\_\_\_ **No record of substantiated maltreatment was found**

\_\_\_\_\_ **Records indicate that maltreatment occurred by the individual.**

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