WEST VIRGINIA
Department of
Health & Human Resources

Authorization and Release for Protective Services and Provider Record Checks for Adoption/Foster Care Only

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:

_____

_____

Type of Agency you are completing this form for:

___ Specialized Foster Care Agency/Adoption Agency

___ Foster Family Home

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

____G Household Member of a Foster Home

____G 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

(Over)

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, Institutional Investigation Unit records and foster care provider 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, including any history I have had with Social Services. **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 understand that any involvement I have had with the WVDHHR as a client or foster care provider will be evaluated and may 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

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_____No record of substantiated maltreatment was found

_____ Records indicate that maltreatment occurred by the individual.

_____Records indicate prior IIU investigations (Copies attached to this document).

_____Records indicate a past CPS and/or APS activity for this individual.

_____Records indicate a past or current foster care provider record for this individual.

IF THIS CLIENT HAS ANY QUESTIONS PLEASE CONTACT THE FOLLOWING COUNTY:

COUNTY: _____

INTAKE#: _____

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