STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES

Authorization and Release for Protective Services And Provider Record Checks for All Resource/Foster and Kinship/Relative Providers

Please complete and sign below. The form must be legible, and all fields must be **filled out completely**.

Name (Print 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:

_____

_____

Please list all addresses or the county(s) and state(s) of all previous residences:

_____

_____

_____

List maiden name, all aliases, or names known by. Print full name(s); do not use initials:

_____

Name of Agency who will receive results/verification of the protective services check:

ND DHHS, Criminal Background Check Unit

Agency Address: 600 E Blvd Ave, Dept 325, Bismarck ND 58505-0250

Agency Contact Information: dhscfscbc@nd.gov fax 701-328-0358

Type of Agency:

- ☐ Child Placing Agency (Including resource/foster care providers)
- ☒ DoHS (Resource Family Home/Certified Kinship/Relative Home)
- ☐ Specialized Family Care Agency (Medley)

Certification

I certify that I have not committed any act of child/adult abuse or neglect as determined by a civil or criminal proceeding or through an investigation by the West Virginia Department of Human Services (DoHS) 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 DoHS to conduct a background check on me which includes a search of Child Protective Services records, Adult Protective Services records, Youth Services records, Institutional Investigation Unit records, and foster care provider records maintained by the department. I authorize the DoHS 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 if I have an open CPS/APS investigation the protective service check will not be completed; the open investigation will be documented on the form and returned to the requesting agency. **I understand that a positive history of maltreatment in any DoHS protective services record will affect my becoming a resource/foster care placement provider. I understand that any involvement I have had with DoHS as a client or foster care provider will be evaluated and may also affect my becoming a foster care placement provider.** I release DoHS and/or its agents in providing information pursuant to this authorization for any and all liabilities, claims, or lawsuits.

Signature:_____ **Date:**_____

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DHHR Office Use Only

- ☐ **No record of substantiated maltreatment was found.**
- ☐ **Records indicate that maltreatment occurred by the individual.**
- ☐ **Records indicate current open CPS, and/or APS investigation.**
- ☐ **Records indicate prior or current IIU investigation(s).**
- ☐ **Records indicate involvement in current or past youth service, CPS, and/or APS case as an adult.**
- ☐ **Records indicate a past or current foster care provider record for this individual.**

IF THIS CLIENT HAS ANY QUESTIONS OR NEEDS TO OBTAIN INVESTIGATION RECORDS, THEY MUST CONTACT THE FOLLOWING COUNTY:

COUNTY:_____

INTAKE/CASE #:_____

_____

(DoHS Stamp or Signature of Authorized Individual (Date)