WEST VIRGINIA Department of Health & Human Resources

Authorization and Release for Protective Services and Provider Record Checks for All Resource/Foster Care Placement Providers and Agency Personnel

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:

Commercial Investigations LLC // Goddard Systems, LLC - Results to go to Commercial Investigations LLC

Agency Address: 622 Loudon Road, Suite 201 Latham, NY 12110

Agency Contact Information: 800-284-0906 ext.208 // staff@commercialinvestigationsllc.com

Type of Agency:

- ☐ **Child Placing Agency (Including resource/foster care providers)**
- ☐ **Child Placing Agency (Potential employee)**
- ☐ **DHHR (Resource Family Home/Certified Kinship/Relative Home)**
- ☐ **Residential Provider Agency (Including Psychiatric Residential/Intermediate Care Facilities)**
- ☐ **Emergency Shelter**
- ☐ **Specialized Family Care Agency (Medley)**
- ☒ **Child Care/Head Start**

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 Health and Human Resources (DHHR) 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 DHHR 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 DHHR 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 DHHR protective services record will affect my becoming a resource/foster care placement provider or employee of an agency that provides foster care services or placement. I understand that any involvement I have had with DHHR as a client or foster care provider will be evaluated and may also affect my becoming a foster care placement providers or resource/foster care agency employee.** I release DHHR and/or its agents in providing information pursuant to this authorization from 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 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 #: _____

_____

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