



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

Alex J. Mayer
Cabinet Secretary

Lorie Bragg
Commissioner

**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:

Agency Address: _____

Agency Contact Information: _____

Type of Agency:

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

Bureau for Social Services, 350 Capitol Street, B-18, Charleston, WV 25301

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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- ☐ 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)