DPHHS-QAD/CCL-20A
(Revision 11-10)

OFFICE USE
CAPS# _____
PS# _____

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
For Registered and Licensed Child Care Providers
Criminal / Protective Service / Motor Vehicle
Background Checks

PERSONAL INFORMATION

Section A – Current Information

Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: ☐ Male ☐ Female Date of Birth: _____ Social Security #_____

Section B – Past Residences

Within the last five (5) years, have you…

1. …lived in another state? ☐ Yes ☐ No
2. …lived on or do you now live in an area designated as an Indian reservation? ☐ Yes ☐ No

If you answered yes to the any of the above questions:

- Please state where you have lived since turning 18 in the table below.
- You will need to obtain an out of state background check or a tribal background check at your cost.

City	County	Reservation	State	Dates of Residency (From – To)

Section C – Prior Caregiver Approvals

Have you been… …registered / licensed to care for children before? ☐ Yes ☐ No
…approved, in any capacity, to provide care in a child care facility? ☐ Yes ☐ No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

_____
(Director / Facility Name) (Dates)

_____
(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FACILITY INFORMATION

Section D – Employment Status

The facility that I am working / living at is: Provider #: _____

Director Name / Facility Name: _____

Facility Mailing Address :_____

My ROLE with this facility is (please check all that apply):

Center Use Only:

- ☐ Director
- ☐ Primary Caregiver
- ☐ Aide
- ☐ Substitute Provider
- ☐ Volunteer
- ☐ Non-Provider Staff

Family and Group Only:

- ☐ Director
- ☐ Caregiver
- ☐ Non-Provider Staff
- ☐ Substitute Provider
- ☐ Spouse
- ☐ Adult Child
- ☐ Other Adult
- ☐ Volunteer

My* START DATE *at this facility is: _____

Section E – Authorization Statement and Signature

I, _____ (applicant name), am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with my status as a current or prospective employee of or volunteer for that entity.

I am aware that CFSD, DMV, and DOJ records may contain information that could adversely affect my employment or volunteer status and/or approval as outlined in ARM 37.95.161 and ARM 37.95.176. These records will relate to criminal history records, motor vehicle records as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

_____

Notary Public for the State of Montana

Residing at: _____

My commission expires: _____

Print Form