

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:

- | | |
|--|--|
| <input type="checkbox"/> Director | <input type="checkbox"/> Substitute Provider |
| <input type="checkbox"/> Primary Caregiver | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Aide | <input type="checkbox"/> Non-Provider Staff |

Family and Group Only:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Director | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Primary Caregiver | <input type="checkbox"/> Adult Child |
| <input type="checkbox"/> Caregiver | <input type="checkbox"/> Other Adult |
| <input type="checkbox"/> Non-Provider Staff | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Substitute Provider | |

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 any substantiated report(s) of child abuse or neglect in Montana, criminal history records, and motor vehicle records. 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 _____ (provider or its authorized representative), 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: _____