

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

C	FFICE U	SE
CAPS#		
PS#		

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 Inform							
			Phone #				
Legal Name:(First)	(M: d.		/8.4 - 1.1 x \	(1 +)			
		,	(Maiden)	(Last)			
Aliases/Other Names Used:							
Residential Address:	(Street)			(City)	(State)	(Zip)	
Mailing Address:							
	(Street)			(City)	(State)	(Zip)	
Sex: [] Male []Fe	male Date of Birth:		Social Security #				
Section B – Past Residenc	es						
Within the last five (5) years, have you 1lived in another state? 2lived on or do you now live in an area designated as an Indian reservation? 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 Reside		– To)	
Section C – Prior Caregiver Approvals							
Have you beenregistered / licensed to care for children before? [] Yes [] Noapproved, 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)							

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:	Family and Group Only:						
□ Director □ Substitute □ Primary Caregiver □ Volunteer □ Aide □ Non-Provi	☐ Primary Caregiver						
My START DATE at this facility is:							
Section E – Authorization Statement and Signature	jnature						
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 volunteer status and/or approval as outlined in substantiated report(s) of child abuse or neglecthousehold member, I understand that I am also	ARM 37.95.161 and ARM 37.95.176. The tin Montana, criminal history records, and	ese records will relate to any					
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.	r causes of action which may subsequ	Jently arise from release of this					
NOTE: Any deletions or ove	ersights may result in the denial of	your application.					
Signed: Date:							
(To be signed in front of a nota	ry)						
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:							