Department of Public Health and Human Services
Background Checks Release of Information
Registered and Licensed Child Care Providers
Criminal, Protective Services, and Sexual or Violent Offender Registry

Instructions: This form should be typed and signature must be hand written.

Facility PV # where you plan to work: _____

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

Date of Birth: _____ **Social Security #:** _____
(MM/DD/YYYY)

Authorization Statement and Signature

I, (Applicant Name) _____ am aware that DPHHS/QAD/CCL, has requested confidential information, 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 licensee, employee of or volunteer for a licensed or registered child care facility.

I am aware that Child and Family Services Division (CFSD) and Department of Justice records may contain information that could adversely affect my status/approval as outlined in ARM 37.95.161 and ARM 37.95.176. These records will relate to criminal history records, MT sexual and violent offender registry 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 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.

In full acknowledgement of the above information and notice, I authorize DPHHS to conduct background checks as listed above, and I hereby also release DPHHS from any claims or causes of action which may subsequently arise from release of this confidential information.

Signature: _____ Date: _____

Past Residences: Have you lived outside of Montana or on an Indian Reservation during the past 5 years?
Please list other state(s) or reservation(s) you have lived in during the past five years in the table below:

State	Country (if not USA)	Dates	Reservation

Health Attestation:

Applicant and providers must meet certain personal health requirements. As the agency responsible for child Care registration/licensing, the Department of Public Health and Human Services must ensure that the health of each provider is adequate to meet the demands of the care being provided.

☐ I attest that I have no disabling chronic conditions; physical, mental, or emotional illness that would prohibit me from meeting the requirements of my role type

Signature: _____ Date: _____

Note: This form is only intended for use with the Online Provider Application for Child Care