BACKGROUND CHECKS FOR APPLICANTS OR FOSTER/ADOPTIVE PARENTS

Initial application requirements:
I hereby authorize the Cabinet for Health and Family Services to complete a check of the Kentucky Central Registry (child abuse or neglect), Criminal Records Check, and an address check of the Sexual Offender Registry and provide the results to the agency listed below. I further authorize the Cabinet for Health and Family Services to complete a fingerprint Criminal Records Check (adults only). Fingerprints submitted will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). I understand I have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the Kentucky State Police and its employees from any claim for damages arising from the dissemination of inaccurate information. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

Procedures for obtaining a copy of FBI criminal history record are set forth at 28 C.F.R. 16.30-16.33 or go to the FBI website at http://www.fbi.gov/about-us/cjis/background-checks. Procedures for obtaining a change, correction, or updating of an FBI criminal history records are set forth at 28 C.F.R. 16.34.

Annual application requirements:
I hereby authorize the Cabinet for Health and Family Services to complete a check of the Kentucky Central Registry (child abuse or neglect), Criminal Records Check, and an address check of the Sexual Offender Registry and provide the results to the agency listed below. I understand I have the right to inspect my criminal history record and to request correction of any inaccurate information. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

The information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

[signature] 10-16-18

Signature of the individual (or parent/guardian of household member age 12-17) requesting the check (date)*

Signature of witness (date)

FOR COMPLETION BY THE CHILD-PLACING AGENCY or CABINET STAFF

Name of child placing agency or DCBS office: Necco-Lexington
Name and title of representative: Chelsea Campbell, HRC
Address: 503 Darby Creek Rd
City: Lexington State: KY Zip Code: 40509
Phone: 859-264-9796 Fax: 859-264-9957
Print Name:
Chelsea Campbell
(representative requesting information)
Signature: Chelsea Campbell (date)
(representative requesting information) (date)

Send the completed form to: **Cabinet for Health and Family Services**
Department for Community Based Services
Records Management Section
275 E. Main St., 3E-G
Frankfort, KY 40621
Fax: (502) 564-9554
Email: CHFSDCBS.RMS@ky.gov

*** Authorization provided by signature expires in 30 days**