CFS-400
New 12/11

STATE OF MONTANA
Department of Public Health and Human Services

RELEASE OF INFORMATION PROTECTIVE SERVICE BACKGROUND CHECKS

PLEASE TYPE OR PRINT LEGIBLY

Incomplete or illegible forms may be returned

Legal Name_____
(First Name) (Middle Name) (Maiden Name) (Last Name)
Enter NMN if none

Aliases/Other Names Used _____

Date of Birth:_____ Social Security Number:_____ Sex: □ Male □ Female

Current Mailing Address: _____

_____

Please check as many as apply. **The reason this information is being requested is that I am**:
□ an applicant for employment □ an employee □ a prospective volunteer □ a volunteer

Authorization Statement and Signature

I am aware that this release pertains to 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 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 show that the person has had their caregiver rights to a child terminated. The information provided under this release may contain information that could adversely affect my employment or volunteer status.

I hereby authorize the Department of Public Services, Child and Family Services Division to release confidential information in connection with my status as a prospective or current employee or volunteer in accordance with 41-3-20593)(o) MCA to:

Fort Belknap Indian Community 656 Agency Main Street Harlem MT 59526
Name of Agency Mailing Address

Ramona Horn 406-353-8405 353-4150
Name of Agency Contact Person: Telephone No: Fax No:

I am also aware that although the entities requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidentiality, DPHHS cannot assure that confidentiality will be maintained after this information is released by DPHHS. I hereby release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.

The Department of Public Health and Human Services (DPHHS) does not discriminate on the basis of race, color, religion, creed, political ideas, sex, age, marital status, physical or mental disability, or national origin. If you believe you have been subjected to discrimination contact the DPHHS Human Resources Division at (406) 444-3136 or the Montana Human Rights Bureau at 1-(800)-542-0807, or relay service at 711.

Signed:_____Date:_____
(MUST BE SIGNED IN FRONT OF A NOTARY PUBLIC)

TO BE COMPLETED BY NOTARY PUBLIC:
Taken, sworn, and subscribed to me this _____day of _____A.D. _____

_____ _____
Notary Public for the State of Montana Residing at

_____ _____
Printed name of Notary Public My Commission expires