



**Section C**

**Please check as many as apply:**

- I am an applicant for:  a Child Placing Agency employee/volunteer
- Licensed Kinship Care     Unlicensed Kinship Care     Foster Care
- Adoption     Guardianship

**OR**

- a member of \_\_\_\_\_'s household who is applying to be  
(name of applicant)  
licensed or approved

**Section D (Authorization Statement and Signature)**

As part of the initial and subsequent annual application process for youth care or application for employment/ volunteer of a Child Placing Agency, I am aware that \_\_\_\_\_ (provider or its authorized representative) has requested confidential information from Montana Department of Public Health and Human Services in accordance with 41-3-205(n)and(o), and 52-2-622MCA as part of a review of my personal background in connection with my status as a prospective resource parent, or member of household, employee or volunteer of that entity.

I am aware that this release pertains to 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 a child in their care was adjudicated by a court as a youth in need of care; and/or a history that shows that the person has had their caregiver rights to a child terminated. This release also pertains to any criminal history records and motor vehicle records and may contain information that could adversely affect my approval/licensure as outlined in ARM 37.51.216 or employment/ volunteer status as outlined in ARM 37.93.110 and ARM 37.93.204.

I hereby authorize any law enforcement, motor vehicle or protective services agency to release all records they have regarding me to the State of Montana, Department of Public Health and Human Services. I hereby authorize release of such information by the Department to any Licensed Child Placing Agency (if applicable) in the State of Montana. A copy of this form is as valid as the original.

\_\_\_\_\_  
(Agency Name and Address)

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 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.

**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:**

State of Montana  
County of \_\_\_\_\_

Signed and acknowledged before me on \_\_\_\_\_ day of \_\_\_\_\_ A.D. 20 \_\_\_\_\_

Residing at: \_\_\_\_\_  
Notary Public for the State of Montana

Printed Name: \_\_\_\_\_ My Commission expires: \_\_\_\_\_