



**DEPARTMENT OF  
PUBLIC HEALTH AND HUMAN SERVICES**

**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 Information**

Phone # \_\_\_\_\_

Legal Name: \_\_\_\_\_  
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

**Section B – Past Residences**

**Within the last five (5) years, have you...**

1. ...lived in another state?  Yes  No  
 2. ...lived on or do you now live in an area designated as an Indian reservation?  Yes  No

If you answered yes to the any of the above questions:

- Please state where you have lived 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 Residency (From – To)

**Section C – Prior Caregiver Approvals**

- Have you been...  
 ...registered / licensed to care for children before?  Yes  No  
 ...approved, 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)

**PLEASE COMPLETE BOTH SIDES OF THIS FORM**

# FACILITY INFORMATION

## Section D – Employment Status

**The facility that I am working / living at is:**

Provider #: \_\_\_\_\_

Director Name / Facility Name: \_\_\_\_\_

Facility Mailing Address : \_\_\_\_\_  
(City) (State) (Zip)

**My ROLE with this facility is (please check all that apply):**

### Center Use Only:

- |  |  |
|--|--|
| <input type="checkbox"/> Director          | <input type="checkbox"/> Substitute Provider |
| <input type="checkbox"/> Primary Caregiver | <input type="checkbox"/> Volunteer           |
| <input type="checkbox"/> Aide              | <input type="checkbox"/> Non-Provider Staff  |

### Family and Group Only:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Director            | <input type="checkbox"/> Spouse      |
| <input type="checkbox"/> Primary Caregiver   | <input type="checkbox"/> Adult Child |
| <input type="checkbox"/> Caregiver           | <input type="checkbox"/> Other Adult |
| <input type="checkbox"/> Non-Provider Staff  | <input type="checkbox"/> Volunteer   |
| <input type="checkbox"/> Substitute Provider |                                      |

**My START DATE at this facility is:** \_\_\_\_\_

## Section E – Authorization Statement

I hereby authorize any law enforcement, protective services, or motor vehicle agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services at the addresses below or any related field office:

Quality Assurance Division - Licensure Bureau - Child Care Licensing / Child Care Licensing  
2401 Colonial Dr / PO Box 202953 / Helena MT 59620 / 2121 Rosebud Dr, Ste D / Billings MT 59102

I understand that any information obtained from these checks can be used by the Department to evaluate my application for registration or licensure. I hereby authorize release of such information to any registered or licensed child care facility in the State of Montana employing me or considering my application for employment. A copy of this form is as valid as the original. This release is valid only at the facility listed in Section D. It is valid for a period of at least one year. It may be valid for up to 3 years depending on the facility's license/registration status.

**NOTE: Any deletions or oversights may result in the denial of your application.**

## Section F – Authorization Signature

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(To be signed in front of a notary)

### 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: \_\_\_\_\_