

**STATE OF LOUISIANA
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
CHILD ABUSE AND NEGLECT REQUEST AND CONSENT FORM B**

This form must be completed by any person who is requesting a Child Abuse and Neglect Clearance, and signed by the applicant. This form must be signed by the requestor, who will receive the results of the child abuse and neglect clearance. Completing the optional identifying information fields on the form will assist in conducting an accurate search.

This consent form shall be used for Licensed Out of State Child Care Facilities, Louisiana DCFS Licensed Facilities and Louisiana Department of Health Licensed Therapeutic Group Homes and Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution.

I. Employer's Identifying Information:

*Name of Employer, Agency, or Facility (Print or Type) ND DHHS, Criminal Background Check Unit		*Entity Type <input checked="" type="checkbox"/> Out of State Child Care Facilities <input type="checkbox"/> Louisiana DCFS Licensed Facilities <input type="checkbox"/> Louisiana Department of Health Licensed Therapeutic Group Homes <input type="checkbox"/> Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution	
*Physical Address 600 E Blvd Ave, Dept 325	*City Bismarck	*State ND	*Zip 58505-0250
*Work Phone # (one main contact number is mandatory) 701-328-7575	*Home Phone #	*Alternate Phone #	
Provider # (If Applicable)	Agency License # (If applicable)	EIN # (If Applicable)	

II. Applicant's Information:

*Last Name	*First Name	*Middle Name	
Aliases, Maiden Name, Previous Married Name(s):			
*Date of Birth:	*Place of Birth (city)	*Place of Birth (state)	*Social Security #
*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/other Pacific Islander		*Male Female (circle)	
*Home Phone # (one main contact number is mandatory)	*Cell Phone	*Work Phone #	*Alternate Phone #
*Current Physical Address	*City	*State	*Zip

*Current Mailing Address:	*City	*State	*Zip
*Email Address:			

*Identification Type <input type="checkbox"/> State Issued Driving License <input type="checkbox"/> State Issued Identification	*Identification (ID) #	*State Issued By	*ID Expiration Date
*Marital Status	Spouse (name) (if married)	Spouse (DOB) (if married)	
Previous Spouse (name)	Previous Spouse (DOB)		
Previous Spouse (name)	Previous Spouse (DOB)		

***List previous addresses for the past 5 years:**

Physical Address	City	State	Zip
Physical Address	City	State	Zip
Physical Address	City	State	Zip
Physical Address	City	State	Zip
Physical Address	City	State	Zip
Physical Address	City	State	Zip
Physical Address	City	State	Zip

List children that the applicant has been responsible for:

First Name	Last Name	Date of Birth

*This information will only be used to confirm the accuracy of applicant's agency history.

III. Applicant's Consent

The information given is true and complete to the best of my knowledge. I understand that in signing this form I give permission for DCFS to conduct a clearance of the State Central Registry which contains information with regards to reports of certain valid cases of child abuse and neglect, and release the results to the requestor noted above and licensing agency. Furthermore, this consent shall terminate a year from the date of my signature below. I also understand that I may be contacted by DCFS for additional information needed to finalize the clearance. I understand that the information I provide about myself shall be used solely for the purpose of conducting the State Central Registry check. I consent for DCFS to conduct a clearance of the state central registry and release all valid information to the requestor below for a determination to be made.

Signature of Applicant _____ **Date** _____

IV. Requestors Agreement

I acknowledge that any information received from the Department of Children and Family Services regarding the individual's inclusion in the State Central Registry is confidential and that this information cannot be shared with anyone unless otherwise allowed by State or Federal Laws/Regulations. All applicable federal and state laws and regulations shall apply including but not limited to Louisiana Revised Statute 46:56, which includes criminal penalties for the sharing of confidential information. I hereby certify that I am requesting a check of the State Central Registry, with the written consent of the individual.

Signature of Requestor _____ **Date** _____

*Last Name	*First Name		*Middle Name
*Mailing Address: 600 E. Blvd Ave, Dept 325	*City Bismarck	*State ND	*Zip 58505-0250

If this clearance is being submitted for employment purposes, by a Licensed Out of State Child Care Facility, Louisiana DCFS Licensed Facility, Louisiana DCFS Licensed Therapeutic Group Homes or Out of State Licensed Residential Facilities that house foster children or meet the federal definition of a child care institution the employee's state issued driving license or state issued identification, along with a \$25.00 payment for the clearance must be submitted, in order for the clearance to be processed. If this clearance is being submitted for an Out-of-State child care clearance, a copy of the provider's agency license must be submitted.