

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services

CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CA/N) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM (www.lrc.ky.gov). PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED:

- Child-Placing Agency (Foster/Adoption/Independent Living) Employee or Volunteer (Required by 922 KAR 1:310)
- Residential Child-Caring Facility Employee or Volunteer (Institution/Group Home/Emergency) (Required by 922 KAR 1:300)
- Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380)
- Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151)
- Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383)
- Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352)
- Supports for Community Living (SCL) Employee (Required by 907 KAR 12:010)
- Michelle P. Waiver (Required by 907 KAR 1:835)
- Home and Community Based (HCB) Waiver (Required by 907 KAR 1:160 and 7:010)
- Acquired Brain Injury Waiver Services (Required by 907 KAR 3:090)
- Children's Advocacy Center (Required by 922 KAR 1:580)
- Court Appointed Special Advocate (CASA) (Required by KRS 620.515)
- Personal Care Attendant (Required by 910 KAR 1:090)

Other (If none of the above categories is applicable, please explain the reason for requesting a child abuse or neglect check, including the statutory or regulatory authority for the request):

PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card, or birth certificate):

NAME: _____
(first) (middle) (maiden/nickname/other) (last)

Sex: ___ Race: _____ Date of Birth: _____

Social Security/Individual Taxpayer Identification #: _____

Date of Initial Hire: _____

Present Address: _____

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

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Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

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Previous Address: _____ City State Zip Code

Previous Address: _____ City State Zip Code

Please list your addresses for the last five years. Use another sheet of paper, if necessary.



CENTRAL REGISTRY CHECK

A credit or debit card payment in the amount of ten dollars (\$10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment.

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. 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.

All 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 of the Individual Submitting to the Child Abuse or Neglect Check _____ Date _____

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization for Disclosure of Protected Information, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF EMPLOYER/AGENCY: Intrust Healthcare Attn: Katie Palmer
ADDRESS: 401 Bogle Street, Suite 102 CITY: Somerset
STATE: Kentucky ZIP: 42503 PHONE: 606-676-0638
E-MAIL ADDRESS: katie.palmer@intrust-healthcare.com

RESULTS OF CHILD ABUSE OR NEGLECT CHECK [FOR OFFICIAL USE ONLY]
 No reportable incident found in accordance with 922 KAR 1:470
 Substantiated child abuse found on the registry Date of substantiated finding: _____
 Substantiated child neglect found on the registry Date of substantiated finding: _____
The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights Yes No
 A matter subject to administrative review found in accordance with 922 KAR 1:470
CHECK CONDUCTED ON _____ BY _____