

STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION

INITIAL OR RECERTIFICATION PROGRAMS: CHECK ONE ONLY:

(* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

- | | | |
|---|---|--|
| <input type="checkbox"/> CCFFH/CMA (P) | <input type="checkbox"/> DOH-DDD | <input type="checkbox"/> DHS-Med-QUEST (Other Than DOH- DDD) |
| <input type="checkbox"/> Adult Day Care Center (P) | <input type="checkbox"/> DOH-CAMHD (Other Than Ther.Hms/Staff) | <input type="checkbox"/> DOH-CAMHD- CPO Therapeutic Resource Homes & Staff (P)* |
| <input type="checkbox"/> Hale Mahaolu POS (P) | <input type="checkbox"/> CWS- Hui Hoomalu & Kokua Ohana Staff (P)* | <input type="checkbox"/> DHS-Office of Youth Services (Other Than Safe House Staff) |
| <input type="checkbox"/> Foster Grandparent (B) | <input type="checkbox"/> CWS -CCI & CPO Staff & CPO non-therapeutic resources homes (P)* | <input type="checkbox"/> DHS-Office of Youth Services Safe House Staff (P)* |
| <input type="checkbox"/> Senior Companion (B) | <input type="checkbox"/> CWS- Catholic Charities HI Hale Malama & HOPE | <input type="checkbox"/> CWS Out-of-State Request for CAN Registry |
| <input type="checkbox"/> Respite Companion (B) | <input type="checkbox"/> Waiting Keiki Contract Resource Families (B)* | <input type="checkbox"/> ACCS Out-of-State Request for APS Registry |
| <input type="checkbox"/> Retired Senior Volunteer (B) | <input type="checkbox"/> CWS Contracts-Other Than Already Noted (eg., CCSS, Ohana Conference, HAP, FSS, VCM, DV, Enhanced Healthy Start Title IV-B 2) | |
| <input type="checkbox"/> DOH-ADAD | | |
| <input type="checkbox"/> DOH-AMHD | | |
| <input type="checkbox"/> DOH-OHCA | | |

AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY

REQUESTING INDIVIDUAL OR AGENCY: (Print or type all information)

Name: _____ Phone: _____
 Address: _____ ATTN: _____

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check: **Adult Protective Services (APS)** and/or **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. * Programs with an asterisk-mail copy of results to requesting individual or agency & forward original to CWS FHL Unit noted on the bottom of page 2.

Full name: _____ **Date of Birth:** _____
Social Security Number: _____ **Telephone Number:** _____
Any Alias(es)/Former Name, including Maiden Name: _____

Current Address: _____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and as specified below:

APS Central Registry: 1) Individual is known to the DHS; 2) Abuse allegations confirmed/not confirmed.

CAN Central Registry: 1) Date of CONFIRMED incident (s) only; 2) Type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until _____/_____/_____ or _____.
Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

Signature: _____ **Date:** _____

Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.

Full Name: _____ Date of Birth: _____

APS Central Registry Clearance: The following results are based upon the information provided on Page 1:

- No record of confirmed adult abuse on file. Confirmed report(s) of abuse on file.
- APS Check not requested.

CAN Central Registry Clearance: The following results are based upon the information provided on Page 1:

Type (s) of confirmed child abuse or neglect	Date(s) of Confirmation
<input type="checkbox"/> Physical Harm/Abuse	_____
<input type="checkbox"/> Failure to Thrive	_____
<input type="checkbox"/> Threatened Physical Harm/Abuse	_____
<input type="checkbox"/> Physical Neglect	_____
<input type="checkbox"/> Abandonment	_____
<input type="checkbox"/> Lack of Supervision	_____
<input type="checkbox"/> Medical Neglect	_____
<input type="checkbox"/> Threatened Physical Neglect	_____
<input type="checkbox"/> Sex Abuse	_____
<input type="checkbox"/> Threatened Sex Abuse	_____
<input type="checkbox"/> Psychological Harm	_____
<input type="checkbox"/> Abuse	_____
<input type="checkbox"/> Neglect	_____
<input type="checkbox"/> Threatened Psychological Harm	_____
<input type="checkbox"/> Providing a child with dangerous, harmful, or detrimental drugs as defined by Section 712-1240	_____
<input type="checkbox"/> CAN Check not requested	

Clearance Completed by: _____ Date: _____
DHS or designee Worker's Name Phone Number

DHS-SSD-CWS: *Mail copies of results to requesting agency and forward original results to CWS FHLU.
CWS FHL Unit Address: