

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Child Care

CHILD CARE CENTRAL REGISTRY CHECK

STATE AND/OR FEDERAL LAW REQUIRES A CHILD ABUSE/NEGLECT (CA/N) CHECK AS A CONDITION OF EMPLOYMENT OR SERVICE AS A CHILD CARE/DAY CARE STAFF MEMBER FOR THE FOLLOWING:

- A Licensed Child-Care Center Employee, Volunteer, or Adult Household Member (922 KAR 2:090)
- A Certified Family Child-Care Home Employee, Volunteer, or Adult Household Member (922 KAR 2:100)
- A Registered Child Care Provider Applicant or Adult Household Member (922 KAR 2:180)
- Private Child Care Employee (KRS 199.466)
- Out of State Child Care Employee (42 U.S.C. 9858f, 45 C.F.R. 98.43)

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: _____

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

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

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.



CENTRAL REGISTRY CHECK

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/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 substantiated 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: Office of Licensure & Accreditation
ADDRESS: 700 Governors Dr **CITY:** Pierre
STATE: SD **ZIP:** 57501 **PHONE:** 605-773-3612
E-MAIL ADDRESS: DSSCRS@state.sd.us

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** _____