AUTHORIZATION TO RELEASE INFORMATION
DOUGLAS COUNTY KANSAS

It is Douglas County policy to conduct an investigation of the criminal history record history on employees, volunteers, and final candidates for positions that perform duties within the offices of criminal justice agencies. This release form will not be considered to be part of the employment application and will be filed separately from the application. The information this form contains will not be used to make the employment decision, except in the case of refusal to authorize the investigation.

I hereby request and authorize Douglas County to conduct a criminal investigation and driving record investigation using the information I have provided below. I release Douglas County, its officers, employees, successors, and assigns from any liability that may result from the conduct of such investigation. In order to facilitate the investigation, I willingly provide the following information:

Full Name: _____
First Middle Last

Date of Birth: _____ Sex: _____ Race: _____

Driver's License: _____ State: _____

Social Security Number: _____

Current Address: _____ _____ _____
City State Zip

Maiden Name (If applicable): _____

Telephone: _____ Position: _____

_____ _____
Applicant Signature Date

After completing this form, please insert the form in the envelope provided. Seal and return it to the Department of Youth Services.

For Department Use Only	
Department	Youth Services
Position	Volunteer
CRI Code	C
Agency ORI	KS023013C
Authorization	

FCL 002
REV01/21

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES

FOSTER CARE LICENSING DIVISION

Mailing Address: PO BOX 1424 Topeka, KS 66601
Physical Address: 500 SW Van Buren Topeka, KS 66603
Website: http://www.dcf.ks.gov
Email: DCF.FCL002@ks.gov

Kansas Department for Children and Families

AUTHORIZATON FOR BACKGROUND CHECK

Who Should use this form: This form is to be completed for any person required to have background checks for DCF Foster Care Licensing purposes. **This form shall also be used to update any information as necessary, i.e. name or address change.** The subject of the background check must complete sections 3 and 4. Parent or guardian signature required if background check is for a minor under the age of 18.

In order to be processed, this authorization form must be completed accurately and in full. For fingerprints please use form FP-1020

1	Select all that apply:		Placement Type /Agency (select one):	Role/Affiliation: (Select one)
	A	☐ Foster Care/ Placement	☐ Family Foster ☐ Home Relative ☐ Placement ICPC ☐	☐ Applicant ☐ Resident of home ☐ Alternative Caregiver
	B	☐ Employment/ Provider	☐ Child Placing Agency ☐ JCIC ☐ Residential Center/Group Boarding Home ☐ Other:_____ ☐ Detention/Secure Care Center ☐ Staff Secure Facility ☐ Attendant Care Facility	☐ Employment candidate ☐ Volunteer ☐ Other ☐ Employment candidate not requiring fingerprints
	Have you been fingerprinted for DCF before? ☐ YES ☐ NO			
	Have fingerprints been submitted? YES NO If Yes, Date Submitted:			
	Will this person be providing direct care or services to children in DCF Custody? ☐ YES ☐ NO			

1.1	
	TO BE COMPLETED ONLY WHEN REMOVING AN AFFILIATE.
	This section is required to be completed on all providers in Section 1 Category A Foster Care/Placement and is optional for Providers in Category B Employment/Provider. Sections 2 and 3 will need to be filled out. Section 4 is not required when removing an affiliate.
	Effective Date:
	Reason for removal:

2			
	TO BE COMPLETED BY THE REQUESTING AGENCY		
	Requesting Agency:		
	Facility/Agency/Family Foster Home name or license number to have person affiliated with:		
	If needing to be affiliated with multiple facilities, list all applicable license numbers:		
	Contact Person Name:		
	Street Address:		
	City:	**State:**	**Zip:**
	Phone:	**Email:**	

3					
	First Name	**Middle Name**	**Last Name**	**Date of Birth (MM/DD/YYYY)**	**Gender:** ☐ **Male** ☐ **Female**
	Maiden and/or Any Names Formerly Used (First/Middle/Last):			**SSN:**	**Race:**
	Current Street Address/Apt/Lot#			**If you have lived out of the state of Kansas in the last 5 years, please included all addresses below. Please Include Street/City/State/Zip Dates From/To**	
	City:	**State:**	**Zip**		
	Phone:	**Email:**			

4	**Authorization/Certification** (Select yes or no on each question)	YES	NO		YES	NO
	Have you ever been indicated as a perpetrator in an abuse/neglect investigation involving a child or adult?	☐	☐	Have you ever had your parental rights terminated?	☐	☐
	Have you been found to be a disabled person in need of a guardian or conservator or both?	☐	☐	Have you ever been convicted of a criminal offense?	☐	☐

I give permission for background history to be checked by DCF to determine eligibility for program participation or employment purposes. I understand the information released is for exclusive and confidential use of DCF or designee of the Secretary.

SIGNATURE:_____ **DATE**:_____

PARENT/GUARDIAN Signature (if under 18):_____ **DATE**:_____

RESULTS, DCF USE ONLY:

FCL. 009
Rev. 01/21

Kansas Department for Children and Families
Foster Care Licensing and Background Checks Division
PO BOX 1424 ● Topeka, KS 66601-1424
500 SW Van Buren St ● 2nd Floor ● Topeka, KS 66603
Fax: (785) 296-8609
Website: http://www.dcf.ks.gov

CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Name of the facility (exactly as stated on the license) _____ License # _____

Street Address _____ City _____ Zip Code _____ County _____

Check type of child care facility:

- ☐ Attendant Care Facility
- ☐ Detention Center
- ☐ Family Foster Home
- ☐ Group Boarding Home
- ☐ Staff Secure Facility
- ☐ Residential Center
- ☐ Secure Residential Treatment Facility
- ☐ Secure Care Center
- ☐ Juvenile Crisis Intervention Center

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.

		Yes	No
1.	Do you see a physician regularly for any health condition?	☐	☐
2.	Are you taking any medication regularly?	☐	☐
3.	Have you had any surgery in the past 3 years?	☐	☐
4.	Do you have any handicapping conditions which might interfere with the care of children?	☐	☐

5. Do you have any chronic illness conditions such as:

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Cancer	☐	☐	Alcoholism	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Convulsions	☐	☐	Liver Disease	☐	☐
Lung Disease	☐	☐	Mental Illness	☐	☐	Other	☐	☐

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ _____
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**