



# STUART T. WILSON CPA, PC

Fiscal Intermediary

## Criminal Background Check Authorization Form

*Do not provide any services prior to authorization.*

*You will not be paid for any time worked prior to a clear criminal background check and the completion of required trainings.*

Employer (Participant): \_\_\_\_\_ Organization/Agency: \_\_\_\_\_

Employee Full Name: \_\_\_\_\_

Previous Names Used (Include maiden name): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Driver's License #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**You MUST include a copy of your Driver's License or State ID with this form.**

I authorize the release of my criminal background information and driving record to my employer, to be run ongoing, and to the "Host Agency" which acts as project administrator; and to the "Fiscal Intermediary" which serves as my employer's financial administrator.

Furthermore, I acknowledge that I am required to notify Stuart T. Wilson CPA, PC as soon as possible, but no later than the next business day, if I have been convicted of any crime.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*Results are released to the participant/guardian or case manager.*

**For results contact:**

Participant/Guardian Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

or

Case Manager: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

I would also like a Driver's License Check conducted \_\_\_\_\_  
Employer Initials

**AUTHORIZATION TO DISCLOSE  
EMPLOYEE INFORMATION  
AND RELEASE OF LIABILITY  
(ORR CHECK)**

I, \_\_\_\_\_ authorize Bay Arenac Behavioral Health (BABH) and the  
(print full name)  
BABH Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, \_\_\_\_\_ release BABH and BABH Office of Recipient Rights, its  
(print full name)  
officers, its agents and its employees for disclosing the information requested by me and I shall indemnify and hold harmless should any claims, suits or actions be filed against them.

**PREVIOUS PLACES OF EMPLOYMENT:**

1. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_
2. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_
3. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_
4. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_

Applicant's Signature	Date	Previous Names Used (print)
Witness Signature	Date	Applicant's Birth Date

**INFORMATION TO BE SENT TO:**

\_\_\_\_\_  
Provider/Consumer

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City                  State                  Zip Code                  Fax

<b>RIGHTS OFFICE USE ONLY</b>
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The above applicant  Does  Does not have a substantiated recipient rights violation(s) according to BABH records.

By: \_\_\_\_\_ Date: \_\_\_\_\_  
BABH Office of Recipient Rights

# DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services

(Revised 5-23)

<p><b>COPY PHOTO ID HERE</b></p> <p><b>OR</b></p> <p><b>ATTACH A SEPARATE PAGE</b></p>
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## SECTION 1 – INFORMATION ON PERSON BEING CLEARED

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Name, (First, Middle, Last)

Maiden Name, Aliases, also known as (A.K.A)

Social Security Number

Date of Birth

Address

City

State

Zip Code

Phone Number

Email

I would like to pick up my results in \_\_\_\_\_ County (For Michigan Residents Only).

Signature Required for Individual Being Cleared

Date

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## SECTION 2 – REQUESTER INFORMATION

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Check Appropriate Box

Employer

Volunteer Agency

Out-of-State Child Caring Institution

Out-of-State Adoption/Foster Care Home Screening

Michigan Court/Law Enforcement/Department of Corrections/Prosecuting Attorney

Individual Self-Request

Name of Agency or Organization

Name of Requester

Stuart T. Wilson CPA, PC

Address

City

State

Zip Code

6300 Schade Dr

Midland

MI

48640

Email

Fax

Phone Number

reception@stuartwilsonfi.com

989-832-5404

989-832-5400