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

Community Mental Health for Central Michigan

AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION & RELEASE OF LIABILITY
OFFICE OF RECIPIENT RIGHTS CHECK

I, _____, authorize Community Mental Health for Central Michigan (CMHCM) and the
(Print full name)
CMHCM Office of Recipient Rights to disclose to the Provider/Consumer listed below any and all information in possession of CMHCM regarding any violation of recipients' rights to be free from Abuse or Neglect committed by me.

I, _____, release CMHCM and CMHCM Office of Recipient Rights, its officers, its agents,
(Print full name)
and its employees from any and all liability claims, suits and actions of any nature brought against CMHCM and the CMHCM Office of Recipient Rights, its officers, its agents and its employees, etc., for disclosing information requested by/about me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

PREVIOUS PLACES OF EMPLOYMENT

1._____ Dates employed _____ to _____

2._____ Dates employed _____ to _____

3._____ Dates employed _____ to _____

_____ _____ _____
Applicant's Signature *Date* *Previous Name Used (print)*

_____ _____ _____
Witness Signature *Date* *Title*

_____
Case Coordinator

INFORMATION TO BE SENT TO:

_____ _____
Provider/Consumer *Fax Number*

_____
Street Address *City* *State* *ZIP Code*

RIGHTS OFFICE USE ONLY

☐ The above applicant does not have substantiated Abuse and/or Neglect recipient rights violation(s) according to CMHCM records.

☐ The above applicant does have substantiated Abuse and/or Neglect recipient rights violation(s) according to CMHCM records.

Violations include: _____

_____

_____

_____ _____
CMHCM Office of Recipient Rights Staff Date

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 4-22)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

Name, (First, Middle, Last)	Signature Required for Individual Being Cleared	Date
Maiden Name, Aliases, also known as (A.K.A)	Social Security Number	Date of Birth
Address	City	State Zip Code
Phone Number	Email	

☐ I am completing this for myself.
☐ I would like to pick up my results in County (For Michigan Residents Only).

SECTION 2 – REQUESTER INFORMATION

Check Appropriate Box
☒ Employer ☐ Volunteer Agency ☐ Adoption/Foster Care Home Screening
☐ Court/Law Enforcement/Department of Corrections/Prosecuting Attorney
☐ Other

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

Employers/Volunteer Agencies will ONLY receive responses of NO central registry if the person being cleared has approved this request with their signature. Employers/volunteer agencies will NOT receive notification if the name submitted has any central registry hits per CPL 722.627. For questions about completing this form, please contact the local Michigan Department of Health and Human Services, see attached contact list.