



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: _____

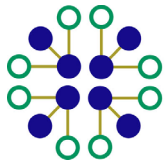
Phone #: _____ Email: _____

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 Information & Release of Liability

Provider Name: _____ Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ ZIP Code: _____

I, _____ (print full name) authorize Community Mental Health for Central Michigan (CMHCM) to disclose to the PROVIDER listed above, any and all information in your possession regarding any violations of recipients' rights committed by me. I recognize that any disclosures cannot include confidential client information protected by any Federal, State or common law.

Please check the appropriate box below:

☐ I acknowledge that I have worked or contracted in the mental health field prior to my application for employment or provider network membership. I have worked in the following counties and give my permission for you to check with their county's Office of Recipient Rights:

☐ I have not worked in the mental health field prior to my application for employment or provider network membership.

I, _____ (print full name) release Community Mental Health for Central Michigan (CMHCM) and any other community mental health agencies I have listed on this form, its officers, agents and employees from any and all liability, claims, suits and actions of any nature brought against them for disclosing the information requested by myself and the provider, and I shall indemnify and hold them harmless should any claims, suits or actions be filed against them.

Applicant's Signature

Date

Applicant's Maiden Name (if applicable)

Witness Signature

Date

XXX-XX-_____
Applicant's Social Security # (last 4 digits only)

Applicant's Home Address: _____
City: _____ State: _____ ZIP Code: _____

RECIPIENT RIGHTS OFFICE USE ONLY

A. The above applicant has the following Recipient Rights history: Violation(s) of Abuse or Neglect according to:

CMHCM: ☐ Yes ☐ No

Name of County: _____ ☐ Yes ☐ No

Name of County: _____ ☐ Yes ☐ No

B. The above applicant has the following Recipient Rights history: Other Rights violation(s) according to:

CMHCM: ☐ Yes ☐ No

Name of County: _____ ☐ Yes ☐ No

Name of County: _____ ☐ Yes ☐ No

CMHCM Recipient Rights Advisor or Officer

Date

Information from other counties was received from:

Name of County and ORR Staff: _____

Name of County and ORR Staff: _____

(Additional forms may be used if there is a need to list more counties)