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, _____ authorize Community Mental Health for Central Michigan (CMHCM)
(print full name)

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, _____ release Community Mental Health for Central Michigan (CMHCM) and
(print full name)

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 by filed against them.

_____ _____ _____
Applicant's Signature *Date* *Applicant's Maiden Name (if applicable)*

_____ _____ XXX-XX-_____
Witness Signature *Date* *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)