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: _____________________________

AUTHORIZATION TO DISCLOSE
EMPLOYEE INFORMATION
AND RELEASE OF LIABILITY

I, ____, authorize Lapeer County Community Mental Health (LCCMH) and the
(print full name)
LCCMH 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 LCCMH and the LCCMH Office of Recipient Rights, its officers, its agents
(print full name)
and it's 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 ____________
5. ____ Dates employed: ____________to ____________

_______________________________ ____________ _______________________________
Applicant's Signature **Date** **Applicant's Maiden Name**

INFORMATION TO BE SENT TO:

Stuart T. Wilson CPA, PC
Provider

Fax: 989-832-5404 brittany@stuartwilsonfi.com
Fax # AND E-Mail Address

RIGHTS OFFICE USE ONLY

The above applicant does ☐ does not ☐ have a substantiated recipient rights violation(s) according to LCCMH records.

_______________________________ _______________________________
LCCMH Office of Recipient Rights Date

DHS-1929, CENTRAL REGISTRY CLEARANCE REQUEST

Michigan Department of Health and Human Services
(Revised 5-23)

COPY PHOTO ID HERE

OR

ATTACH A SEPARATE PAGE

SECTION 1 – INFORMATION ON PERSON BEING CLEARED

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

SECTION 2 – REQUESTER INFORMATION

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