STUART T. WILLSON 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: ____________________________

Livingston County Community Mental Health Authority

AUTHORIZATION TO RELEASE RECIPIENT RIGHTS INFORMATION

I, ____________________ authorize Livingston County Community Mental Health Authority (LCCMHA) Office of Recipient Rights to release to **Stuart T. Wilson CPA** any written reports or records regarding substantiated violations of Recipient Rights. I release LCCMHA Office of Recipient Rights from any and all claims, liability, and damages that may result from the release of these reports or records. I also understand that because of the nature of my job and licensing requirements, the information provided pursuant to this authorization may be provided to representatives of the Department of Health and Human Services and/or other community health agencies. I hereby Consent to the release of this information to these agencies.

____
Applicant's Name (Please Print)

_________________________ ____________
Applicant's Signature Date

____
Other last name that may have been used (i.e. Maiden Name, Married Name)

____________________________ _____________
Witness Signature Date

Our search of the records showed that the individual name above…

_____ Does

_____ Does Not

…have written reports or records on file regarding substantiated violations of recipient rights.

______________________________ _____________
Office of Recipient Rights Date

PROVIDER FAX: _______989-832-5404_________________

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