

**STATE OF LOUISIANA  
DEPARTMENT OF CHILDREN AND FAMILY SERVICES  
CHILD ABUSE AND NEGLECT REQUEST AND CONSENT FORM A**

This form must be completed by any person who is requesting a Child Abuse and Neglect Clearance, and signed by the applicant. This form must be signed by the requestor, who will receive the results of the child abuse and neglect clearance.

**This consent form shall be used for Out of State Child Protective Service Agencies Conducting Investigations, and Out of State Agencies Certifying Foster/Adoptive Homes for Foster Children.**

**I. Agencies Identifying Information:**

|   |                                  |  |                    |
|---|----------------------------------|--|--------------------|
| *Name of Child Protective Services Agency, or Certifying Foster/Adoptive Home or Agency (Print or Type)<br><br>NDDHHS, Criminal Background Check Unit |                                  | *Entity Type<br><input type="checkbox"/> Out of State CPS Agency Conducting Investigation<br><input checked="" type="checkbox"/> Out of State Agencies Certifying Foster/Adoptive Homes for Foster Children. |                    |
| *Physical Address<br>600 E Blvd Ave, Dept 325   | *City<br>Bismarck                | *State<br>ND   | *Zip<br>58505-0250 |
| *Work Phone # (one main contact number is mandatory)<br>701-328-7575  | Home Phone #                     | Alternate Phone #  |                    |
| Provider # (If Applicable)  | Agency License # (If applicable) | EIN # (If Applicable)  |                    |

**II. Applicant's Identifying Information:**

|   |                        |                         |                    |
|---|------------------------|-------------------------|--------------------|
| * Last Name   | *First Name            | *Middle Name            |                    |
| *Aliases, Maiden Name, Previous Married Name(s):  |                        |                         |                    |
| *Date of Birth:   | *Place of Birth (city) | *Place of Birth (state) | *Social Security # |
| *Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African-American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/other Pacific Islander |                        | *Male Female (circle)   |                    |
| *Home Phone # (one main contact number is mandatory)  | *Cell Phone #          | *Work Phone #           | *Alternate Phone # |
| *Current Physical Address   | *City                  | *State                  | *Zip               |
| *Current Mailing Address:   | *City                  | *State                  | *Zip               |

|  |   |                          |                                |  |
|--|---|--------------------------|--------------------------------|--|
| <b>*Identification Type</b><br><input type="checkbox"/> State Issued Driving License<br><input type="checkbox"/> State Issued Identification |   | <b>*Identification #</b> | <b>*State Issued By</b>        | <b>*Identification Expiration Date</b> |
| <b>*Marital Status</b>   | <b>*Spouse (name) (if married, mandatory)</b> | <b>*Spouse (DOB)</b>     |                                | <b>*Spouse (race)</b>                  |
| <b>*Previous Spouse (name) (if divorced, mandatory)</b>  | <b>*Previous Spouse (DOB)</b>                 |                          | <b>*Previous Spouse (race)</b> |  |
| <b>*Previous Spouse (name) (if divorced, mandatory)</b>  | <b>*Previous Spouse (DOB)</b>                 |                          | <b>*Previous Spouse (race)</b> |  |
| <b>*Email Address:</b>   |   |                          |                                |  |

**\*List previous addresses for the past 5 years:**

|                  |      |       |     |
|------------------|------|-------|-----|
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |
| Physical Address | City | State | Zip |

**\*List children that the applicant has been responsible for:**

| First Name | Last Name | Date of Birth | Social Security # | Race |
|------------|-----------|---------------|-------------------|------|
|            |           |               |                   |      |
|            |           |               |                   |      |

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**III. Applicant’s Consent (This section is not required if this request is from another State Agency conducting a Child Protection Investigation)**

The information given is true and complete to the best of my knowledge. I understand that in signing this form I give permission for DCFS to conduct a clearance of the State Repository which contains information with regards to reports of all valid cases of child abuse and neglect. Furthermore, this consent shall terminate a year from the date of my signature below. I understand that the information I provide about myself shall be used solely for the purpose of conducting the Child Abuse and Neglect Clearance, and valid findings contained in the State Repository will be released. I consent for DCFS to conduct a clearance of the state repository, and release all valid information to the requestor below for the out of state requestor to make a determination.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**IV. Requestors Agreement**

I acknowledge that any information received from the Department of Children and Family Services regarding the individual’s inclusion in the State Repository is confidential and that this information cannot be shared with anyone unless otherwise allowed by State or Federal Laws/Regulations. All applicable federal and state laws and regulations shall apply including, but not limited to Louisiana Revised Statute 46:56, which includes criminal penalties for the sharing of confidential information. I hereby certify that I am requesting a check of the Louisiana State Repository of child abuse and neglect, with the written consent of the individual.

**Signature of Requestor** \_\_\_\_\_ **Date** \_\_\_\_\_

|  |                          |                     |                           |  |
|--|--------------------------|---------------------|---------------------------|--|
| <b>*Last Name</b>                                    |                          | <b>*First Name</b>  |                           |  |
| <b>*Mailing Address:</b><br>600 E Blvd Ave, Dept 325 | <b>*City</b><br>Bismarck | <b>*State</b><br>ND | <b>*Zip</b><br>58505-0250 |  |