MINNESOTA PRAIRIE COUNTY ALLIANCE-DODGE SITE
22 E 6TH STREET, DEPT 401, MANTORVILLE, MN 55955

CONSENT AND REQUEST FOR LAW ENFORCEMENT AND AGENCY RECORDS

I, _____
(Name of Individual)
hereby authorize the County Sheriff's Office, City Police Department, State Patrol, Department of Natural Resources, Court Administration, County Attorney's Office, or County Social Services Department to disclose to Minnesota Prairie County Alliance information regarding an all records check (specific data/records, type of information, appropriate dates): **Criminal or non-criminal type activity including that which reflects violence and drug or alcohol use or abuse.**

The individual identified above has applied for/employed by/residing in:

Adult Foster Care, Child Foster Care, Family Day Care licensing, or Legal-Non Licensed Child Care

(please circle the appropriate one)

The Human Services Licensing Act requires that licensing agencies conduct an applicant background study (investigation) on all members of the applicant's household, 13 years of age and older. Records will be requested from the Minnesota Bureau of Criminal Apprehension and other law enforcement agencies. Information will also be requested from county social service agencies pertaining to report of maltreatment of children or adults. This information is required in order to complete an application for adult foster care licensing, child foster care licensing, or family day care license. MN Chapter 245A.04, Subd. 3.

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that in any event this consent expires automatically as described below.

This Consent for the Release of Information shall expire one year from the date on which I execute this consent form. I also understand that if I do not receive a clearance letter within 15 business days of the initiation of this study that additional time is needed for completion.

I hereby acknowledge notice that this study will be done and give my consent to any of the above-listed (named) agencies, offices and departments to release any data of which I am the subject, whether such data is private or public. I also consent to release of records any present or former adult or child foster care, or family day care, from designated county or agency.

_____ _____
Date **Signature**

_____
Signature of parent or guardian if needed

List all addresses where you have resided in the last five years (street, city, state, county):

_____

_____

_____

Please complete the following section:

IDENTIFYING INFORMATION:

Name of individual on whom information is requested*

_____

(Last) (Maiden/Alias) (First) (Full Middle)

_____

(Street Address) (City) (State & Zip)

Driver's License Number _____

Date of Birth: _____ Place of Birth: _____

Sex: _____Female _____Male Social Security Number:_____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Scars, marks, tattoos, or any other identifying characteristics: _____

Race: (Check one)

____ White ____Hispanic ____Black
____ American Indian ____Asian or Pacific Islander
____ All Others

Please indicate reason for background study: ___Household Member ___Adult Caregiver ___Substitute ___Helper (13-18 years of age) ___Other, explain

_____

***Name of family, facility, or agency requesting licensure if different from above:**

_____

(Last) (First) (Middle)

_____

(Address) (City) (State/Zip)

A photocopy of this form shall be accepted in place of the original.

***FOR AGENCY USE ONLY**

INFORMATION REQUESTED IS AS FOLLOWS:

_____

_____
_____
_____

Signed: _____ Date: _____

Title: _____ Agency: _____