

**STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION**

**INITIAL** OR  **RECERTIFICATION** PROGRAMS: CHECK ONE ONLY:

(\* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CCFH/CMA (P)                  | <input type="checkbox"/> DOH-DDD  | <input type="checkbox"/> DHS-Med-QUEST (Other Than DOH- DDD)                         |
| <input type="checkbox"/> ACCS General (B)              | <input type="checkbox"/> DOH-CAMHD (Other Than Ther.Hms/Staff)  | <input type="checkbox"/> DOH-CAMHD- CPO Therapeutic Resource Homes & Staff (P)*      |
| <input type="checkbox"/> ACCS Out-of-State Request (B) | <input type="checkbox"/> CWS- Hui Hoomalu & Kokua Ohana Staff (P)*  | <input type="checkbox"/> DHS-Office of Youth Services (Other Than Safe House Staff ) |
| <input type="checkbox"/> Adult Day Care Center (P)     | <input type="checkbox"/> CWS -CCI & CPO Staff & CPO non-therapeutic resources homes (P)*  | <input type="checkbox"/> DHS-Office of Youth Services Safe House Staff (P)*          |
| <input type="checkbox"/> Foster Grandparent (B)        | <input type="checkbox"/> CWS- Catholic Charities HI Hale Malama & HOPE Waiting Keiki Contract Resource Families (B)*                                  | <input type="checkbox"/> CWS Out-of-State Request for CAN Registry                   |
| <input type="checkbox"/> Senior Companion (B)          | <input type="checkbox"/> CWS Contracts-Other Than Already Noted (eg., CCSS, Ohana Conference, HAP, FSS, VCM, DV, Enhanced Healthy Start Title IV-B 2) | <input type="checkbox"/> CWS General   |
| <input type="checkbox"/> Respite Companion (B)         |   |  |
| <input type="checkbox"/> DOH-ADAD                      |   |  |
| <input type="checkbox"/> DOH-AMHD                      |   |  |
| <input type="checkbox"/> DOH-OHCA                      |   |  |

**AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY**

**REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)**

Name: Family Programs Hawai'i Phone: 521-9531 ext. 228  
 Address: 250 Vineyard St. ATTN: Vince Abramo  
Honolulu, HI 96813 Volunteer Coordinator

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check:  **Adult Protective Services (APS)** and/or  **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. \* Programs with an asterisk-mail copy of results to requesting individual or agency and forward original to CWS FHL Unit noted on the bottom of page 2.

Full name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Any Alias(es)/Former Name, including Maiden Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until \_\_\_\_/\_\_\_\_/\_\_\_\_ or \_\_\_\_\_.  
 Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.**

