

AUTHORIZATION FOR BACKGROUND CHECK for Child Care

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

CHECK ONE BOX IN EACH COLUMN IN EITHER ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home/Facility
1	A Child Care in the Home Unlicensed/Licensed/ Applying for	<input type="checkbox"/> Unlicensed Day Care Home <input type="checkbox"/> Day Care Home <input type="checkbox"/> Group Day Care Home	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (ages 13 to 17)* *Parent/Guardian signature required <input type="checkbox"/> Member of Household (age 18 and over) <input type="checkbox"/> Employee/Volunteer <input type="checkbox"/> Ward
	B Child Care Facility (other than a home) Exempt/Licensed/ Applying for	<input type="checkbox"/> Child Welfare Agency <input checked="" type="checkbox"/> Day Care Center <input type="checkbox"/> Day Care Agency <input type="checkbox"/> Youth Emergency Shelter <input type="checkbox"/> Group Home <input type="checkbox"/> Child Care Institution/Maternity Center <input type="checkbox"/> License Exempt Facility	<input type="checkbox"/> Applicant/Operator (Person applying to operate a licensed child care facility) <input type="checkbox"/> Executive Director <input checked="" type="checkbox"/> Employee/Volunteer

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial _____		Social Security or ITIN Number _____ - _____ - _____							
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____		List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) Dates From/To							
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: _____ City: _____ State: ____ ____ Zip Code: ____ - ____ - ____ County: _____ Home Telephone (____ - ____) _____ - _____ Cell Phone (____ - ____) _____ - _____									
Date of Birth (Month/Date/Year) ____ - ____ - ____		Age _____	Place of Birth (City and State) _____	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In. _____	Weight (lbs.) _____	Hair (color) _____	Eye (color) _____
<input type="checkbox"/> Native American/Alaskan (Indian or Eskimo) <input type="checkbox"/> Asian		Race (Check all that apply) <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Identify <input type="checkbox"/> Could not be Verified						Ethnicity (see codes on Page 2)	

AUTHORIZATION /CERTIFICATION

3	Have you ever been indicated as perpetrator in a child abuse/neglect investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever been convicted of a criminal offense, other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	I certify that I have read and understood the Authorization/Certification box on the back page of this form.
SIGNATURE _____ DATE _____	
Parent/Guardian Signature (if applicable) _____ DATE _____	

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization will not be processed without completion of this section. The licensing representative or child's worker must complete the following	
Date Fingerprinted: _____	Supervising Agency Name: DCFS _____
Full Name of Facility Illiana Migrant & Seasonal Head Start	Provider ID# _____
Provider ID # 507858	Or DCFS Region/Site/Field Danville
Street Address: ** 150 S. Randolph Street	Stacey Black 217 443 3200
City Sheldon IL ZIP: 60966	Name of Worker Worker ID#/Phone Number
	Name of Supervisor Supervisor ID#/Phone Number

5	BACKGROUND RESULTS AS APPLICABLE	FOR CENTRAL OFFICE OF LICENSING USE
	Sex Offender Clearance: _____	SID# _____ Clear _____ Record _____
	CANTS Clearance: _____	BC-03 Registered: _____
	Illinois State Police Clearance: _____	FBI Sent Out: _____
	FBI Clearance: _____	
Transfer Clearances: SO/CANTS: _____ ISP: _____		

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a child care facility, or be employed by or volunteer at a day care or group day care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
Race:	Enter all race codes that apply. NA = Native American/Alaskan (Indian or Eskimo) WH = White AO = Asian UK = Unknown BL = Black/African American DI = Declined to Identify PI = Native Hawaiian/Pacific Islander CV = Could not be Verified
Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HA = Hispanic Central American HS = Hispanic South American HN = Hispanic Dominican HM = Hispanic Mexican HO = Hispanic Other HP = Hispanic Puerto Rican UK = Unknown HD = Hispanic Spanish Descent DI = Declined to Identify HC = Hispanic Cuban CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -		Instructions for Right Side -	
Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)	Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)	Provider ID #:	
Street/City/Zip:	The site of licensed facility where person is licensed or employed.	DCFS Region/Site/field:	The DCFS Region/Site/Field.
		Name of the Worker:	Name, ID and phone of the worker
		Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search child abuse and neglect reports to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. The child abuse and neglect background check and the criminal history investigation may be used for considering an application for license, current or prospective employment, or service as a volunteer in a child care facility. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential but may be shared with my employer, prospective employer, the licensing applicant for whom my background check is required or with authorized licensing staff in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny the application for licensure or may result in the termination of my employment.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: <http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html> for the ISP and <http://www.fbi.gov> for FBI.