

I, _____, give permission for the release of information concerning
(PRINT ONLY)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* ATTN: KS WORK UHC Program Phone 1-877-908-1747
Agency name Public Partnerships LLC (PPL)
Agency mailing address ATTN: KS WORK UHC, 8000 Avalon Blvd, Suite 300
Agency email address _____
Alpharetta, GA 30009

Check box if agency is a CDDO, CMHC, or ILRC

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address:

Street City State Zip Code
DOB: ____/____/____ SS#: ____-____-____ Male Female
(mm/dd/yyyy) (mark one)

I understand that all information released will be for the exclusive and confidential use of the above-named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. ____Yes ____No

Signature: _____ Date: ____/____/____
(mm/dd/yyyy)

Per statute 65-6205: Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:

DCF.APSRegistry@KS.GOV

or

Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

FOR PPS ADMINISTRATION USE ONLY:

Record Found? No Yes "Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.
If yes, check all that apply Abuse Neglect Exploitation Fiduciary Abuse
Perpetrator's Name: _____ Date Substantiated: _____
Initial: _____ Date: _____