

# STATE OF COLORADO



Colorado Department of Human Services

people who help people



## OFFICE OF PERFORMANCE IMPROVEMENT

Jenise May, Interim Director

## EMPLOYMENT AFFAIRS DIVISION

3550 West Oxford Avenue, 2<sup>nd</sup> Floor

Denver, Colorado 80236

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Matthew Flora, Statewide Services Interim Director

Bill Ritter Jr.

Governor

Karen L. Beye

Executive Director

## BACKGROUND INVESTIGATION UNIT INDIVIDUAL INQUIRY FORM

One of the following must be marked in order for BIU to process your request: Volunteer Employment Adoption  
Foster Care Other (Explain) \_\_\_\_\_

Please note: Your signature must be notarized and accompanied by a check or money order for \$10.00 made payable to: CDHS, BIU, Records & Reports, 3550 W. Oxford Ave., Denver, CO 80236.

### INDIVIDUAL MAKING REQUEST

### PLEASE PRINT LEGIBLY

\_\_\_\_\_  
First Name Middle Name Last Name Alias/Maiden Name

\_\_\_\_\_  
Date of Birth Sex: M/F Race Social Security Number

\_\_\_\_\_  
Current Address City/State/Zip Code Phone Number

\_\_\_\_\_  
Mailing Address City/State/Zip Code

\_\_\_\_\_  
Previous Address City/State/Zip Code

### SPOUSE/FORMER SPOUSE/PARENT(S) OF YOUR CHILDREN (Add additional names on a separate sheet of paper)

\_\_\_\_\_  
First Name Middle Name Last Name Alias/Maiden Name

\_\_\_\_\_  
Date of Birth Sex: M/F Race Social Security Number

### CHILDREN – Use full names. (Add additional children on a separate sheet of paper)

1) \_\_\_\_\_  
Complete Name Date of Birth Sex: M/F

2) \_\_\_\_\_  
Complete Name Date of Birth Sex: M/F

3) \_\_\_\_\_  
Complete Name Date of Birth Sex: M/F

4) \_\_\_\_\_  
Complete Name Date of Birth Sex: M/F

Any person who willfully permits or who encourages the release of data or information related to child abuse or neglect contained in TRAILS to persons not permitted access to search information commits a class 1 misdemeanor pursuant to §18-1.3-501, C.R.S.

\_\_\_\_\_  
Signature of Individual (If under the age of 18, parent signature required.)

\_\_\_\_\_  
Date of Request

**Notary Statement:** STATE of \_\_\_\_\_  
COUNTY of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

My Commission Expires: \_\_\_\_\_

**Notary Seal:**

\_\_\_\_\_  
Signature of Notary

***If you wish for the background check results to be sent to a representative or agency other than yourself, please complete the following Waiver and Authorization.***

**WAIVER AND AUTHORIZATION TO RELEASE INFORMATION**

I authorize the Colorado Department of Human Service, Background Investigation Unit (CDHS-BIU) to release the results of the background check to the representative and/or agency listed below.

**RELEASE INFORMATION TO:**

**PLEASE PRINT LEGIBLY**

Agency/Company Name: Northeast Behavioral Health, LLC

Name Of Individual: Nacole Shawcross

Mailing Address: 1300 North 17th Avenue

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature of Individual (If under the age of 18, parent signature required.)

\_\_\_\_\_  
Date