DPP-156 (R. 8/2019) 922 KAR 1:470

Kentucky.gov

## COMMONWEALTH OF KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

**Department for Community Based Servi** 

## CENTRAL REGISTRY CHECK

FOR THE FOLLOWING TYPES OF EMPLOYMENT OR VOLUNTEERISM, STATE LAW OR KENTUCKY ADMINISTRATIVE REGULATION AUTHORIZES A CHILD ABUSE/NEGLECT (CAN) CHECK AS A CONDITION OF EMPLOYMENT OR VOLUNTEERISM (www.Irc.kv.gov). PLEASE CHECK THE CATEGORY LISTED BELOW THAT APPLIES TO YOU FOR WHICH THE CHILD ABUSE OR NEGLECT CHECK IS BEING REQUESTED: Child-Placing Agency(Foster/Adoption/Independent Living)Employee or Volunteer (Required by 922 KAR 1:310) Residential Child-Caring Facility Employee or Volunteer (Required by 922 KAR 1:300) (Institution/Group Home/Emergency/Wilderness) Public School Employee, Student Teacher, Contractor, or School-Based Decision-Making Council Member (Required by KRS 160.380) Private, Parochial, or Church School Employee or Student Teacher (Permitted by KRS 160.151) Youth Camp Employee, Contractor, or Volunteer (Required by KRS 194A.380-194A.383) Power of Attorney Regarding the Care and Custody of a Child (Required by KRS 403.352) Supports for Community Living (SCL) Employee (Required by 907 KAR 12:010) Michelle P. Waiver (Required by 907 KAR 1:835) ☐ Home and Community Based (HCB) Waiver (Required by 907 KAR 1:160 and 7:010) Acquired Brain Injury Waiver Services (Required by 907 KAR 3:090) \_\_ Children's Advocacy Center (Required by 922 KAR 1:580) Court Appointed Special Advocate(CASA) (Required by KRS 620.515) Personal Care Attendant (Required by 910 KAR 1:090) Other If you are requesting this check due to it being required or authorized for an out of state employer, please include the state or federal law that requires or authorizes the check be completed. If none of the above categories are applicable, please explain the reason for requesting a child abuse or neglect check, including the state or federal law providing authority for the request. If a state or federal law is not listed, your request will be cancelled and no refund will be issued. Medicaid: in-home service provider 907 KAR3:030 PERSONAL INFORMATION REGARDING THE INDIVIDUAL SUBMITTING TO A CHILD ABUSE OR NEGLECT CHECK (Please print and submit identifying information such as a copy of your driver's license, social security card/individual taxpayer ID, passport, work ID, or birth certificate): If you are under the age of 18, a parental consent form MUST be uploaded. Shenika Name: Lanee N/A Breed (maiden/nickname/other) (last) (first) (middle) **Date of Birth:** 07/25/1997 Sex: Race: Black or African American **Date of Initial Hire:** 01/30/2025 **Social Security/Individual Taxpayer Identification #:** 405-08-9638



An Equal Opportunity Employer M/F/D

<b>Present Address:</b>	3216 Stegner Ave, Louisville , KY, $402$	16		
		City	State	Zip Code
<b>Previous Address:</b>				
		City	State	Zip Code
<b>Previous Address:</b>				
		City	State	Zip Code
<b>Previous Address:</b>				
		City	State	Zip Code
<b>Previous Address:</b>				
		City	State	Zip Code

Use another sheet of paper, if necessary.

## CENTRAL REGISTRY CHECK

A credit or debit card payment in the amount of ten dollars (\$10.00) must accompany your request to process a Child Abuse or Neglect Check. The Child Abuse or Neglect Check will NOT be processed without payment.

I hereby authorize the Cabinet for Health and Family Services to complete a Child Abuse or Neglect check and to submit the results of the check to me and, on my behalf, to the employer or agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

All the information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

Shenika Breed 02/10/2025
Signature of the Individual Submitting to the Child Abuse or Neglect Check Date

The individual authorizing a Child Abuse or Neglect check may submit a CHFS-305, Authorization to Disclose Protected Health Information form, authorizing the Cabinet for Health and Family Services to disclose additional information regarding a finding to the employer or agency listed below should the employer or agency request additional information pursuant to 922 KAR 1:510, Authorization for disclosure of protection and permanency records.

In addition to receiving the results myself, I authorize the Cabinet for Health and Family Services to share the results with the following employer or agency:

NAME OF 1	EMPLOY	ER/AGENC	<b>Y:</b> <u>Tr</u>	ransformations	Hope for Toda	ys Families LLC	
EMAIL AD	DRESS:	jpolley@trans	formations	sllc.net			
ADDRESS:	4 <u>010 Dupoi</u>	nt Circle			C	ITY: Louisville	
STATE:	KY		ZIP:	40207	PHONI	E:	
RESULT	TS OF CH	IILD ABUSE	E OR NE	EGLECT		[FOR OFFICIAL USE ONLY	
X Nor	eportable i	ncident found	d in accor	rdance with	922 KAR 1:	470	
Subs	stantiated c	child abuse fo	ound on tl	he registry			
	Date of sub	stantiated					
Subs	stantiated c	hild neglect f	found on	the registry			
I	Date of sub	stantiated					
		buse or negle ary termination	`	_		, sexual exploitation, a child fatality	, near
—	natter subje CONDUCTE		trative re /10/2025		in accordanc Delores Hurt	ee with 922 KAR 1:470	

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