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

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.lrc.ky.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 KAR 3:030

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.

Name:	Susan	Elizabeth	Newman	Andersen
	(first)	(middle)	(maiden/nickname/other)	(last)

Sex: F **Race:** White **Date of Birth:** 06/15/1969

Social Security/Individual Taxpayer Identificaiton #: 286-80-5588 **Date of Initial Hire:** 03/01/2022

Present Address: 138 Ardmore Crossing Dr, Shelbyville, KY, 40065

City State Zip Code

Previous Address: 123 Plantation Dr, Shelbyville, KY, 40065

City State Zip Code

Previous Address:

City State Zip Code

Previous Address:

City State Zip Code

Previous Address:

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.

Susan Andersen *09/10/2023*

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 EMPLOYER/AGENCY: Transformations LLC

EMAIL ADDRESS: jpolley@transformationsllc.net

ADDRESS: 4010 Dupont Cir **CITY:** Louisville

STATE: KY **ZIP:** 40207 **PHONE:**

RESULTS OF CHILD ABUSE OR NEGLECT **[FOR OFFICIAL USE ONLY]**

☒ No reportable incident found in accordance with 922 KAR 1:470

☐ Substantiated child abuse found on the registry

Date of substantiated

☐ Substantiated child neglect found on the registry

Date of substantiated

The substantiated abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, near fatality, or involuntary termination of parental rights ☐ Yes ☐ No

☐ A matter subject to administrative review found in accordance with 922 KAR 1:470

CHECK CONDUCTED ON 09/15/2023 **BY** Sherry Marcum

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