

**DHS Criminal Check Form**

**OPENING DOORS PROGRAM  
NON PROFIT Organization**

Date:

The following named individual is part of a group of respite care, child care providers on the referral listing for Opening Doors. Refusal to complete or provide the information necessary to ensure an accurate study will result in immediate disqualification to work with the Opening Doors Program.

Last Name Applicant:

First Name:

Middle Name:

Maiden, Alias or Former:

Address:

City/State/Zip:

Phone Number (optional):

MN Drivers License or State ID#

Date of Birth:

month / day / year

Sex:

Male Female

(Select one)

Social Security Number (optional):

Race (optional):

I authorize the Department of Human Services to disclose all criminal history record or licensing information to Opening Doors for the purpose of placing my name on the referral list of respite and child care providers with Opening Doors.

The expiration of this authorization shall be for a period of no longer than one year from the date of my signature.

\_\_\_\_\_  
Signature of Applicant

Date