



Arkansas Department of Human Services
Division of Children and Family Services
REQUEST FOR CHILD MALTREATMENT CENTRAL REGISTRY CHECK

THIS FORM WILL NOT BE PROCESSED UNTIL ALL INFORMATION IS COMPLETED.

TYPE OF APPLICANT:

DHS Employee/Applicant [Division: _____] Foster Parent Legal Custodian Adoptive Parent Provisional Foster Parent

Foster Family Support System (FFSS) for: _____
Name of Foster Family whom FFSS will support

Other (This request will be processed for a fee of \$10 made payable by check or money order to DHS. We do not accept cash. This fee may be waived for non-profits who provide proof of 501(c)(3) status. Allow 7-10 business days for processing.)

This information should be addressed to:

_____	_____	
Name/Title (print)	Organization Requesting the Report	
_____	_____	_____
Address (physical)	Telephone #	Fax #
_____	_____	_____

Address (provide mailing, if different than physical)

Name of Applicant: _____ Maiden Name/Other Names Used: _____ Race: _____ Sex: _____ Age/DOB: _____ / _____ SSN: _____

Present Address: (since _____, _____) _____

Previous Addresses (from the last six years):

- | | |
|---------------------------------|---------------------------------|
| 1) _____
From _____ to _____ | 2) _____
From _____ to _____ |
| 3) _____
From _____ to _____ | 4) _____
From _____ to _____ |

Cities and States of Employment (outside of Arkansas) for last six years:

- | | |
|---------------------------------|---------------------------------|
| 1) _____
From _____ to _____ | 2) _____
From _____ to _____ |
|---------------------------------|---------------------------------|

3) _____

From _____ to _____

4) _____

From _____ to _____

Children (related or non-related) now residing or who have resided in the home at any time and all biological children, even if they have not resided in the home:

Full Name: _____
DOB/Age: _____ / _____
Relationship: _____
SS# (if known): _____

Full Name: _____
DOB/Age: _____ / _____
Relationship: _____
SS# (if known): _____

Full Name: _____
DOB/Age: _____ / _____
Relationship: _____
SS# (if known): _____

Full Name: _____
DOB/Age: _____ / _____
Relationship: _____
SS# (if known): _____

THE FOLLOWING IS TO BE COMPLETED ONLY WITH A NOTARY

I, _____ verify that the information above is true and complete. I authorize the Arkansas Child Maltreatment Central Registry to release any information their files may contain concerning me as an offender of a true report of child maltreatment.

Signature of Applicant

Date

County of _____ State of Arkansas

Acknowledged before me, this _____ day of _____, _____

Notary Public

My commission expires: _____

THE FOLLOWING IS TO BE COMPLETED BY CENTRAL REGISTRY

The Arkansas Child Maltreatment Central Registry contains no record under the referenced name in a true report of child maltreatment.

Examiner's Initials and Date _____

Please note that whenever there is a determination of child maltreatment, the person identified as the offender has the right to a hearing to contest that determination. The person's name may not be placed in the Central Registry until after the hearing decision. Therefore, the absence of a true report in the Child Maltreatment Central Registry does not imply that the person is or is not the subject of a completed child maltreatment investigation. Please check the Central Registry periodically as names can be added to the Central Registry based on new maltreatment reports and upon final administrative determination.

Information Found

Examiner's Signature and Date _____

Child Maltreatment Central Registry
Slot S 566
P O Box 1437
Little Rock AR 72203