STATE OF KANSAS
Department for Children and Families
Prevention and Protection Services

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

PPS 10400
REV 7/15

I, _____ , give permission for the release of information concerning
(PRINT ONLY)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* Nathan Fawson , Executive Director **Phone** 620/365-8641

Agency name Southeast Kansas Mental Health Center

Agency mailing address PO Box 807, Iola, KS 66749

☐ **Check box if agency is a CDDO, CMHC, or ILRC**

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** ___ - ___ - ___ Sex: ☐ M or ☐ F
(mm/dd/yyyy)

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and the information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse and Neglect Central Registry each year while I am employed or associated with the above agency. ☐ **Yes** ☐ **No**

Signature: _____ **Date:** _____
(mm/dd/yyyy)

Per statute 65-6205: Community Service Providers, Mental Health Centers and Independent Living Centers may request information for the purpose of obtaining background information on applicants for employment without signed consent. Signature is not required from the individual for which the inquiry is made.

RETURN TO:

Adult Abuse Registry
555 S. Kansas Ave
Topeka, Kansas 66603-3444

FOR PPS ADMINISTRATION USE ONLY:
Record found?

Yes ☐ **No** ☐ If yes, finding: ☐ Abuse ☐ Neglect ☐ Exploitation ☐ Fiduciary Abuse (check all that apply)

"Yes" indicates the individual is listed on the adult abuse, neglect, exploitation registry.

Perpetrator's Name: _____

Region: _____ Date Substantiated: _____

Initial: Date: