CATHOLIC CHARITIES of the Diocese of Tulsa

Most Reverend Edward J. Slattery, Bishop of Tulsa

Kevin M. Sartorius
Executive Director

P.O. Box 580460
Tulsa, Oklahoma 74158-0460
918.949.HOPE (4673)
Fax: 918.582.2123
www.CatholicCharitiesTulsa.org
E-Mail: info@CatholicCharitiesTulsa.org

MADONNA HOUSE APPLICATION

General Applicant Information

Date: _____

Name: _____ SSN #: _____
(Last) (First) (Middle)

Date of Birth: _____ Phone #: _____

Email Address: _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed _____

Other names you have used: _____

Education (check highest level of education completed)

Some High School _____ H.S. diploma/G.E.D. _____ Some college _____
College degree or higher _____

Have you ever served in the U.S. Military? _____ Yes _____ No
If yes, provided dates of service: _____ to _____

Are you currently pregnant? Yes/No
Baby's due date: _____ or birth date: _____

List all individuals with whom you are currently living:

Last Name	First Name	Age	Relationship to you

_____

_____

_____

List the names/ages of any other children not currently living with you and indicate with whom they are living:

Last Name	First Name	Age	Who child lives with

Please provide the following information concerning the baby's father:

Name: _____

Address: _____ Phone: _____
(Street) (City) (State) (Zip) (include area code)

Age:_____

When was the last time you had contact with this baby's father?

_____

What is the current status of your relationship with the baby's father? (circle one)

Together Not Together Divorced Separated Uncertain

Is there a history of drug abuse related to the baby's father or his friends or relatives? (circle one)

Yes No Uncertain

Is there a history of physical or verbal abuse related to the baby's father or his friends or relatives? (circle one)

Yes No

Is the baby's father planning to participate in the baby's life? (circle one)

Yes No Uncertain

Please describe the issue(s) that led you to apply for housing at Madonna House:

_____

_____

_____

_____

_____

APPLICANT RESIDENTIAL HISTORY

Current Address:

_____
(Street) (City) (State) (Zip) Phone (Include area code)

Dates of Residency: _____to_____

Is current address the home of: Self Friend Relative Motel Shelter (Circle one)

Prior Addresses
(Please include information for the 5 years prior to submitting this application)

1) Previous address:
_____
(Street) (City) (State) (Zip)

Phone: _____ Dates of Residency: _____ to _____

List all persons with whom you lived at this address and their relationship to you:
Name Relationship

_____

_____

_____

_____

2) Previous address:

_____

(Street) (City) (State) (Zip)

Phone: _____ Dates of Residency: _____ to _____

List all persons with whom you lived at this address and their relationship to you:

Name Relationship

_____

_____

_____

_____

(If additional space is needed, please use the back of this sheet).

Have you ever lived in other shelters or transitional housing, lived as an adult rent-free in another person's home and/or subsidized housing? Yes _____ No _____ (If Yes, indicate below)

Name of person, shelter, etc.: _____

Address: _____

(Street) (City) (State) (Zip) Phone (Include area code)

Dates of Residency: _____to _____

(If additional space is needed, please use the back of this sheet).

APPLICANT FINANCIAL HISTORY

Do you have any unpaid debts? (check all that apply)

_____ Utilities _____ Rent _____ Bank loans _____ Car loans

_____ Education _____ Court fines _____ Child support _____ Medical bills

_____ Other

In addition to income, do you receive any of the following? (check all that apply)

_____ Disability/SSI _____ Child Support _____ Food Stamps _____ WIC

APPLICANT EMPLOYMENT HISTORY

(Please include information for the 5 years prior to submitting this application)

Current Employer:
Place of Employment: _____ Job Title: _____

Address: _____ Phone: _____
(Street) (City) (State) (Zip) (Include Area Code)

Date(s) of Employment: _____ Number of hours worked/week: _____

Hourly Wage: $ _____ per hr/wk/month. Gross pay/ month: $ _____

If you are not currently employed, please check here: _____

Previous Employer:
Place of Employment: _____ Job Title: _____

Address: _____Phone: _____
(Street) (City) (State) (Zip) (Include Area Code)

Supervisor: _____ Salary: _____

Dates of Employment: _____ to _____ Reason for leaving _____

Previous Employer:
Place of Employment: _____Job Title: _____

Address: _____Phone: _____
(Street) (City) (State) (Zip) (Include Area Code)

Supervisor: _____ Salary: _____

Dates of Employment: _____ to _____Why did you leave? _____

If additional space is needed, please use the back of this sheet.

APPLICANT HEALTH HISTORY

Are you currently pregnant? _____ Yes _____ No

If yes, what is the due date of the child? _____

Are there any complications with this pregnancy/ are you considered high risk?

_____ Yes _____ No If yes, please describe: _____

Are you enrolled in SoonerCare? ____ Yes _____ No

Are you currently under a physician's care? ___ Yes ____ No

If yes, please indicate the following:

Physician:
Name: _____

Address:_____ Phone: _____
(Street) (City) (State) (Zip) (Include area code)

If you are not pregnant, indicate the delivery date of your youngest child

_____

Indicate the number of previous pregnancies: _____
Of those pregnancies, how many were: Miscarriage(s): _____ Abortion(s): _____ Adoption(s): _____

Medical Issues:

Please list any medical conditions/disabilities with which you have been diagnosed or for which you are receiving treatment:

_____

_____

_____

Mental Health:

1. **Have you seen a mental health provider/counselor/therapist in the past 10 years? If yes, please provide the following information regarding those providers:**

Name: _____
Address: _____ Phone: _____
(Street) (City) (State) (Zip) (include area code)
Name: _____
Address: _____ Phone: _____
(Street) (City) (State) (Zip) (include area code)

2. **Are you experiencing any of the following symptoms/problems? (please circle all that apply)**

Moodiness	Conflicts with others	Changes in/trouble sleeping
Uncontrolled anger	Impulsivity	Lack of friends/loneliness
Sadness	Feelings of worthlessness	Nervousness/anxiety
Obsessive	Unreasonable fear/panic	Discomfort in crowds
Argumentative	Changes in eating patterns	Suicidal Thoughts
Visual hallucinations (seeing things that are not present)	Auditory hallucinations (hearing things that are not present)	Homicidal Thoughts

Please list any mental health conditions with which you have been diagnosed or for which you are receiving treatment:

Condition	Date of Diagnoses	Receiving Treatment?	Hospitalizations due to condition? Include dates.
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____
		Yes/No	Yes/No Dates: _____

Prescription Medication:

Please complete the following chart concerning medications currently prescribed to you.

Medication	Condition for which medication prescribed	When did you begin taking this medication?

Substance Use History:

Tobacco:

1. Have you ever used any forms of tobacco? ____Yes ____No
2. If yes, what form(s) of tobacco have you used in the past? (check all that apply)
   ____Cigarettes _____Cigars _____E-cigarettes ____Chewing Tobacco
   ____Other
3. How many times on an average day do you use tobacco?
   _____
4. Have you ever been involved in a program to help you quit using tobacco?
   _____Yes _____No
5. If so, which self-help group was used?
   _____

Alcohol

1. Have you previously used alcohol? ____Yes ____No
2. If yes, age of first use: _____
3. Have you used alcohol in the past 30 days? _____ Yes _____ No
4. Frequency of alcohol use (check one):
   _____ less than once/month
   _____ monthly
   _____ weekly
   _____ several times/week
   _____ daily
   _____ several times/day
5. When you use alcohol, how many drinks to you usually consume (check one):
   _____ one
   _____ two – three
   _____ four – five
   _____ more than five
6. Have you previously been involved in a program to help you stop using alcohol?
   _____ Yes _____ No
7. If yes, indicate the name(s) of the program(s) and provide approximate dates of attendance:

   _____

   _____

Drug Use

1. Have you previously used illegal drugs? _____ Yes _____ No
2. If yes, please list:
   _____
   _____
3. Have you used in the past 30 days? _____Yes _____No
4. Approximate date of last use: _____ Drug(s) used: _____
5. Describe frequency of use (check one):

_____ less than once/month _____ monthly _____ weekly
_____ several times/week _____ daily _____ several times a day

6. **Have you been involved in a program to help you quit using drugs?** ___Yes ___No
7. **If yes, indicate the name(s) of the program(s) and provide approximate dates of attendance:**

_____

_____

Family and Relationships History:

1. **Is there a family history of addictions?** ____Yes _____No

2. **If yes, please describe:**

_____
_____
_____

3. **How would you describe your relationship with your family?**
___Good __Fair ___Poor ___Close ____Stressful ___Distant ___Other

4. **Identify the people who are supportive of you: (Check all that apply)**
___Parents ___Other family ___Friends ____ Church group ____ Boyfriend
____ Other

APPLICANT LEGAL HISTORY

1. **Have you ever been arrested and/or charged with a crime?**
_____ Yes _____ No
2. **If yes, please indicate the charge(s) and approximate date(s) of those charges:**

_____

_____

_____

_____

3. **Are you currently or have you ever been on probation?** _____ Yes _____ No
4. **Do you currently or have you ever had a case before DHS?**
_____ Yes _____No
If yes, please describe the circumstances of your case, and indicate whether and how it was resolved or whether it is still pending.

_____

_____

Are you or have you ever been affected by any of these situations? (Check all that apply)

___Domestic Violence ___ Substance Abuse ___ Eviction ___ Child custody (Removal)

Please describe:

_____

_____

_____

_____

Is this a current issue? Y / N
When was the last time these incidents occurred? _____

PLEASE READ CAREFULLY and Initial the following:

_____I understand that if I do not abide by the rules of Catholic Charities then I will not be able to reside at the Madonna House.

_____I understand that there will be mandatory meetings, classes, and appointments, including weekly counseling, required if I decide to stay at the Madonna House.

_____I understand that I may have to undergo drug/alcohol testing during my stay at Madonna House.

The above information is true and correct to the best of my knowledge.

Applicant Signature:_____Date:_____

Interviewer Signature:_____Date:_____

Coordinator Signature:_____Date:_____

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Authorization for Disclosure of Confidential Information

I, _____, authorize the disclosure and use of my personal information as it relates to the following agencies/persons:

I authorize the following person(s) and/or organization(s) to disclose and/or receive my personal, confidential information:

Name of Individual(s) and/or Organization(s)	Contact Information

I further authorize the below person(s) and/or organization(s) to receive information from the above stated (the below authorized may also disclose my information, as necessary, to the above authorized person(s) and/or organization(s):

Name of Individual(s) and/or Organization(s)	Contact Information

Specific Information that may be disclosed by the above authorized parties:

__Fact Sheet
__Social Service Reports
__Consultation
__Mental Health Information
__Lab Reports
__History and Physical
__Medical Records
__Psychiatric Records
__Discharge Summary
__Counseling Records
__Drug/Alcohol Care/Treatment
__Felony Record(s)
__DHS Progress Reports
__Court Documents
__WIR Documents
__Madonna House Progress Reports
__DVIS Records
__My Children's Records, as applicable
__Contact Information
__***All of my information including, but not limited to, anything referenced above***

The above information is authorized to be disclosed for the following purpose(s):

__At the request of the named individual(s) and/or organization(s)
__Service Planning
__Continued Treatment
__DHS Case
__DVIS Case
__Legal Action
__Child Custody Hearing(s)
__Family Request(s)
__Other (if other, please specify below): _____

This authorization shall be valid until:

__Six months from the date of this signed document
__One year from the date of this signed document
__Until the following date:_____

Right to Revoke

I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Catholic Charities and/or Madonna House have already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Privacy/Compliance Officer
Catholic Charities
2450 N. Harvard Ave.
Tulsa, OK 74115

I understand that my services/treatment cannot be conditioned on whether I sign this authorization.

I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) and/or organization(s) that I authorize to receive my confidential information are not subject to federal and state information privacy laws, subsequent to disclosure by such person(s) and/or organization(s) may not be protected by those laws.

I understand that this information disclosed may include, when applicable, information relating to communicable or venereal disease (including, but not limited to, diseases such as hepatitis, syphilis, gonorrhea) and the Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex).

I understand that alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I am entitled to receive a copy of this authorization.

_____ _____
Client Signature (person providing the authorization) Date

_____ _____
Client Representative Signature (if applicable – read below under "Translation") Date

TRANSLATION: This is to certify that the above Authorization has been read to the client (or client representative) in his/her native language. All representatives which appear in the Authorization were understood and authorized by the client (or representative).

_____ _____
Interpreter Signature Date

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Request for an Individual's Health Information

I, Last Name _____ First_____ Middle_____

Other Names used_____ Date of Birth_____ SSN_____

Address_____ City/State/Zip_____

Home Phone #_____ Cell Phone #_____ Work Phone #_____

[ ] authorize the disclosure and use of MY protected health information
or
[ ] authorize the disclosure and use of MINOR CHILD protected health information,

Child's Last Name_____ First_____ Middle_____

Other Names used_____Date of Birth_____ SSN_____

As described herein,
I authorize the following person(s) and/or organization(s) **to disclose** the health information (as specified below):

_____
(Print Name of Individual or Organization)

_____
(Print Address)

I authorize the following person(s) and/or organization(s) **to receive** the health information, as disclosed by the person(s) and/or organization(s) above:

_____
(Print name of individual or organization)

_____
(Print Address)

Specific description(s) of the health information that I authorize for disclosure:

☐ Fact Sheet	☐ History and Physical	☐ Drug/Alochol Care/Treatment
☐ Entire Record	☐ Counseling Records	
☐ Discharge Summary	☐ Consultation	☐ Lab Report
☐ Social Service Reports	☐ Psychiatric Records	

Other _____
_____

For the following purpose:

- ☐ Continued Treatment
- ☐ At the Request of the Individual*
- ☐ Service Planning
- ☐ Referral

Other (specify)_____

*(Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.)

This authorization is valid until:

- ☐ Six months from the date of the signature
- ☐ The following date: _____

Right to Revoke

I understand that I have the right to revoke this authorization, in writing, at any time, and that the revocation will be effective except to the extent that Catholic Charities and/or Madonna House have already taken action in reliance on my authorization. My written statement that I want to revoke my authorization should be delivered to:

Privacy/Compliance Officer
Catholic Charities
2450 N. Harvard Ave.
Tulsa, OK 74115

I understand that my services/treatment cannot be conditioned on whether I sign this authorization.

I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) and/or organization(s) that I authorize to receive my confidential information are not subject to federal and state information privacy laws, subsequent to disclosure by such person(s) and/or organization(s) may not be protected by those laws.

I understand that this information disclosed may include, when applicable, information relating to communicable or venereal disease (including, but not limited to, diseases such as hepatitis, syphilis, gonorrhea) and the Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex).

I understand that alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I am entitled to receive a copy of this authorization.

_____ _____

Client Signature (person providing the authorization) Date

_____ _____

Client Representative Signature (if applicable – read below under "Translation") Date

TRANSLATION: This is to certify that the above Authorization has been read to the client (or client representative) in his/her native language. All representatives which appear in the Authorization were understood and authorized by the client (or representative).

_____ _____

Interpreter Signature Date

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Consent for Care and Treatment

I, _____, consent to care and treatment at Catholic Charities Counseling Services, including assessment, evaluation, and therapeutic counseling as may be deemed necessary or advisable. I understand that my treatment with Catholic Charities is voluntary. I understand I have the right to accept or refuse recommended treatment and/or procedures.

Release of Information

All records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations.

Information (including the fact that the person is a client here) will not be released to another person without explicit written permission and consent, except for the special circumstances listed below:

- Professionals at this agency may discuss cases among themselves for consultation in planning the most effective course of treatment.
- Parents or guardians of minors have a right to have the counselor's general impression of the child's difficulties and progress; however, the counselor reserves the right to keep specific details of the child's counseling confidential.
- If there are legal actions involved, records may be released and/or counselor's testimony reuested if a court order is obtained.
- There are two situations in which professionals are required by law to disregard confidentiality:
    1) If the client reveals information indicating a clear and imminent danger to harm self or others, the professional will contact the appropriate authorities, family members and/or the threatened person.
    2) All helping professionals are required by law to report any knowledge or suspicion of abuse of a child or an aged, disabled or incompetent person.

Financial Responsibilities

I understand that I am responsible for any amount due in consideration of counseling services rendered. All amounts estimated or known to be payable by me become due at the time of service (including, but not limited to, my agreed upon *per visit fee* and previous balance, if any).

Certification

I certify that I have read each of the above statements. I have had each item explained to me to my satisfaction and that I am the client or am duly authorized by the client to sign this agreement and accept its terms.

_____	_____	_____
Client, Guardian, or Authorized Person	Date	Relationship
_____	_____	
Witness	Date	

Madonna House Mission Statement

Madonna House, named in honor of the Blessed Virgin Mary, is a safe, secure and supportive home for you and your baby. Madonna House is supported by Catholic Charities, whose duty and responsibility it is to uphold the teachings of Christ and the Church on the truth, beauty, and goodness of being a woman and being a mother of children.

Being in our Blessed Mother's home we are inspired to follow her example: purity of heart, chastity, and receptivity to God's love and grace. The following are commitments established for all who live and work at Madonna House:

- To practice/work on self-control in accordance with the Roman Catholic Church's teaching, which reserves the gift of sexuality for the Sacrament of Marriage
- To attend weekly counseling with a Catholic Charities Licensed counselor
- To be mindful of the truth that healthy friendships are not only possible, but necessary in the Christian life and to encourage one another in forming and sustaining them
- To always remember I am in a community that will need me to be thoughtful, courteous, flexible, and willing to communicate and cooperate
- To be drug and alcohol free and committed to addressing these issues if they are an area of concern
- To foster a spirit of fellowship in which one may share with others thoughts and experiences to ensure that no one faces the joys and challenges of mothering alone
- To encourage each other to begin to heal past memories, restore trust in God, and renew hope in His plan for our happiness
- To be receptive to God's Love and Grace by prayer, spiritual reading, meditations, etc.

_____ I have read the mission statement and communal living rules for Madonna House and I understand if I do not abide by them I will not be able to stay at Madonna House.

_____ I understand that I will be required to attend mandatory meetings and appointments if I decide to stay at Madonna House.

_____ I understand I may have to undergo drug testing and room searches during my stay at Madonna House.

Signature_____ Date_____

Staff_____ Date_____

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Name:_____

Please write a paragraph answering the two reflective questions below:

For what purpose have a chosen Madonna House of Catholic Charities Tulsa as a place for me to reside? What do I hope to accomplish as a resident of Madonna House?

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Drug Test Consent and Results Form

I, _____, do consent to be screened for drugs by Madonna House Staff or approved volunteer.

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Name: _____ Date of Test: _____

Positive Results for: (Check box for each positive result):

- ☐ COC: Cocaine
- ☐ mAMP: Methamphetamine
- ☐ THC: Marijuana
- ☐ BZO: Benzo
- ☐ Lower Level Opiates

Comments: _____

_____

I ACKNOWLEDGE THE RESULTS OF MY DRUG SCREENING BY SIGNING BELOW:

Signature: _____ Date: _____

Coordinator Signature: _____ Date: _____

AmericanChecked, Inc.

Investigative / Consumer Report Disclosure & Release

In connection with my employment/volunteerism or application for employment (including contract for services and volunteer work), an investigative consumer report and consumer reports, which may contain public record information, may be requested from AMERICANCHECKED, INC. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drugs/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background, or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency, or other source which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records.

I authorize AMERICANCHECKED, INC. to prepare a consumer report or investigative consumer report about me for employment/volunteer-related purposes. I have been provided a copy of the summary of the rights of the consumer pursuant to the Fair Credit Reporting Act (FCRA).

I hereby fully release and discharge AMERICANCHECKED, INC., their respective affiliates, subsidiaries, directors, officers, employees, agents and attorneys thereof, and each of them, and any individual, organization, entity, agency, or other source providing information to AMERICANCHECKED, INC. from all claims and damages arising out of or relating to any investigation of my background for employment/ volunteer purposes. This release is valid for all federal, state, county and local agencies, authorities, previous employers, military services and educational institutions.

AMERICANCHECKED, INC. is authorized to disclose all information obtained to the requesting entity for the purpose of making a determination as to my eligibility for employment/volunteerism, promotion or any other lawful purpose. I agree that such information, and my employment history, may be supplied to AMERICANCHECKED, INC. If hired or contracted, this authorization shall remain on file and shall serve as ongoing authorization for the procurement of consumer reports at any time during my employment/volunteerism or contract period.

By signing below, I certify that I have read and fully understand this release, that prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction, and that I executed this release voluntarily and with the knowledge that the information being released could affect my being hired, my employment/volunteerism, or my eligibility for promotion.

Today's Date

_____Signature_____

Print your full name _____

For purposes of gathering this information, I agree to supply the following information, which may be required by law enforcement agencies and other entities for positive identification purposes when checking records. It is confidential and will not be used for any other purpose.

Print other last names you have used _____

List States and Counties of Residence for the past: □ 3 years □ 5 years □ 7 years □ 10 years
(Attach a separate sheet if more space is needed.)
State _____City/County _____ From _____ to _____

State _____City/County _____ From _____ to _____

State _____City/County _____ From _____ to _____

State _____City/County _____ From _____ to _____

Home Address _____

City _____ State _____ Zip

Social Security No. _____ Date of Birth _____

Driver's License No. _____ State Issuing License_____

Sex: Male Female Race: Asian Black Hispanic White Other _____
(circle one) (circle one)

You have the right to receive, upon your written request within a reasonable period of time, (not to exceed 30 days) a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AMERICANCHECKED, INC., upon proper identification, to request the nature and substance of all information in its files on you at the time of your request, including the sources of information, and the recipients of any reports on you that AMERICANCHECKED, INC. has previously furnished within the two-year period preceding your request. AMERICANCHECKED, INC. may be contacted by mail at 4870 S. Lewis Ave. Ste. 211, Tulsa, Oklahoma, 74105, or by phone at (800) 975-9876.

(Oklahoma, Minnesota, or California residents requesting a copy of their credit report will receive a copy of the report pulled directly from Trans Union LLC)

☐ Oklahoma Applicants Only: I request a copy of any *credit* report requested on me.
☐ Minnesota Applicants Only: I request a copy of any consumer report requested on me.

Notice to California Applicants
Under California law, the consumer reports we order on you for employment purposes within the State of California are defined as investigative consumer reports. These reports may contain information on your character, general reputation, personal characteristics and mode of living. Under section 1786.22 of the California Civil Code, you may view the file maintained on you by AMERICANCHECKED, INC. during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at AMERICANCHECKED, INC. in person, by mail, or by telephone. AMERICANCHECKED, INC. may be contacted by mail at 4870 S. Lewis St Ste. 211 Tulsa, Oklahoma, 74105, or by phone at (800) 975-9876. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

☐ I request to receive a free copy of any investigative consumer report ordered on me by checking this box.
(California applicants only)
Please complete the following:

Name_____

Address_____

City_____ Zip _____

Company Name: _____ **Location No**.: _____
Attached to this disclosure is a written summary of your rights under the Fair Credit Reporting Act (FCRA) as prepared by the Federal Trade Commission.

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation, Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051