



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
 DIVISION OF LEGAL SERVICES  
**DMU DOCUMENT REQUEST**

DOCUMENT MANAGEMENT UNIT  
 PO BOX 1527  
 JEFFERSON CITY, MO 65102  
 PHONE: (573) 751-1013  
 PHONE: (866) 258-9241  
 EMAIL: DLS.DMU@DSS.MO.GOV

PLEASE PRINT LEGIBLY

**PAGE 1 OF 2 TO BE COMPLETED BY REQUESTING PARTY**

I understand there may be fees assessed for processing this document request. These may include research fees, media fees and shipping costs.

I  Accept  Decline Responsibility for possible processing fees incurred related to this document request   
 Initial

If requesting documents via electronic mail, please provide a copy of your drivers license or photo ID   
 Initial

Please make all business checks (attorneys only), cashier's checks and money orders payable to:  
**"DSS Administrative Trust Fund"**

Please select here if you would like all correspondence from the Document Management Unit to be via E-mail  Yes  No

**SECTION I - TO BE COMPLETED BY THIRD PARTY REQUESTOR**

ORGANIZATION/COMPANY/AGENCY	REQUESTOR'S NAME	
ADDRESS (NUMBER AND STREET NAME)	CITY, STATE, ZIP CODE	
E-MAIL ADDRESS	TELEPHONE NUMBER	MO BAR NUMBER
CLIENT'S NAME	CLIENT'S SOCIAL SECURITY NUMBER	CLIENT'S DATE OF BIRTH

**A SIGNED, HIPAA-COMPLIANT (IF APPLICABLE) RELEASE OF INFORMATION MUST ACCOMPANY THIS REQUEST (CONTINUE TO SECTION II)**

**SECTION 1A - TO BE COMPLETED BY SELF/PARENT**

REQUESTOR'S NAME	TELEPHONE NUMBER
ADDRESS (NUMBER AND STREET NAME)	CITY, STATE, ZIP CODE
E-MAIL ADDRESS	
SOCIAL SECURITY NUMBER	DATE OF BIRTH

**SECTION II - REQUESTOR'S RELATIONSHIP TO THE INDIVIDUAL(S) THEY ARE REQUESTING INFORMATION ABOUT**

<input type="checkbox"/> PARENT OF MINOR CHILD <input type="checkbox"/> SELF <input type="checkbox"/> FOSTER CHILD (FIRST COPY FREE) <input type="checkbox"/> OTHER (PLEASE EXPLAIN) _____ <input type="checkbox"/> GAL (MODIFICATIONS, CUSTODY, DISSOLUTIONS) <b>ATTORNEY FOR PARENT</b> A. <input type="checkbox"/> MATERNAL <input type="checkbox"/> PATERNAL B. <input type="checkbox"/> COURT APPOINTED <input type="checkbox"/> PUBLIC DEFENDER PRIVATE ATTORNEY C. <b>JUVENILE CASE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (DISK ONLY)	<input type="checkbox"/> CIRCUIT ATTORNEY/PROSECUTOR <input type="checkbox"/> LAW ENFORCEMENT/JO/DJO <input type="checkbox"/> GAL (IN JUVENILE COURT CASES ONLY) <input type="checkbox"/> CPS FROM ANOTHER STATE <b>FOSTER PARENT:</b> LICENSURE FILE: FIRST COPY: <input type="checkbox"/> YES <input type="checkbox"/> NO FOSTER CHILD CURRENTLY PLACED IN THEIR FOSTER HOME: FIRST COPY: <input type="checkbox"/> YES <input type="checkbox"/> NO
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**SECTION III - ITEM REQUESTED: (PLEASE DESCRIBE THE INFORMATION YOU ARE REQUESTING AND WHO IT IS REGARDING, AND IF THERE ARE ANY TIME FRAMES RELEVANT TO YOUR REQUEST. YOU MAY USE THE BACK OF THIS SHEET IF NECESSARY.)**

<input type="checkbox"/> REQUESTED RECORDS TIME FRAME (IF APPLICABLE) _____ THIS IS FOR REVIEW BEFORE THE CHILD ABUSE AND NEGLECT REVIEW BOARD DATE OF REVIEW _____ CHILD ABUSE AND NEGLECT (CA/N) RECORDS _____ (CALL NUMBER OR SPECIFIED TIME FRAME)	OTHER
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PREFERRED MEDIA AND NUMBER OF COPIES OF EACH REQUESTED \_\_\_\_\_PHOTOCOPY \_\_\_\_\_DISC \_\_\_\_\_EMAIL \_\_\_\_\_USB  
**IF YOU DO NOT SELECT A MEDIA TYPE, YOU WILL AUTOMATICALLY RECEIVE AN EMAIL OR DISC**

**SECTION IV - SIGNATURE REQUIRED**

SIGNATURE	DATE
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**SECTION V - IDENTIFICATION VERIFICATION**

Identification of requesting party was verified

Initial

Authorized user/client provide copy of client Drivers License or Photo ID  
Relationship verified

Initial

Relationship to all child(ren) \_\_\_\_\_

**SECTION VI - COUNTY REQUIRED INFORMATION**

Are victim child(ren) currently in alternative care:  Yes  No

Has there been TPR:  Yes  No Date of TPR: \_\_\_\_\_

Has child been adopted:  Yes  No Date of Adoption: \_\_\_\_\_

**SECTION VII - COUNTY CONTACT INFORMATION**

COUNTY OFFICE

COUNTY EMPLOYEE NAME

COUNTY EMPLOYEE TELEPHONE/CONTACT NUMBER

TIME EXPENDED (EX: RETRIEVING, COPYING, SCANNING RECORDS, ETC. AS APPLIES)

**SECTION VIII MULTIPLE COUNTY CONTACT**

MULTIPLE COUNTIES INVOLVED

YES  NO

COUNTY(IES) CONTACTED

DATE CONTACTED

**SECTION IX ATTESTATION OF RECORD**

I, \_\_\_\_\_ attest to the best of my knowledge that all records are copied and/or  
STAFF MEMBER NAME  
electronically uploaded to the applicable application for review by the Document Management Staff.

SIGNATURE

DATE

**OPTIONAL ADDITIONAL REQUEST INFORMATION**