

Application Therapeutic Foster Parent A Healthy Future Program

Applicant 1		Applicant 2	
Last name, First, MI		Last name, First, MI	
<u>Race</u> (check all that apply): <input type="checkbox"/> Alaskan Native Tribe: _____ <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiaq <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimsian <input type="checkbox"/> Yupic <input type="checkbox"/> American Indian Tribe: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <u>Ethnic Background</u> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other: _____		<u>Race</u> (check all that apply): <input type="checkbox"/> Alaskan Native Tribe: _____ <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiaq <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimsian <input type="checkbox"/> Yupic <input type="checkbox"/> American Indian Tribe: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <u>Ethnic Background</u> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other: _____	
Religious Affiliation (optional): _____ Education (last grade completed): _____		Religious Affiliation (optional): _____ Education (last grade completed): _____	
Social Security #		Social Security #	
Work Phone	Home Phone	Work Phone	Home Phone
Mailing Address	City/Village	State	Zip
Street Address	City/Village	State	Zip
Location, if different from street address/directions to home			
Marriage (if applicable): Date: _____ City: _____ County: _____ State: _____			
Length of time share household with co-applicant (if applicable)			
Persons living in the household (Include yourself and your own children, including those living in the household part time but not foster children.)			
<u>Name</u>	<u>Birth date</u>	<u>Age</u>	<u>Drivers License #</u>
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
For additional persons us a separate page			
Willing to care for: Number of children ____ Age: ____ to ____ Any age <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either <input type="checkbox"/> Specific child(ren) only <input type="checkbox"/>			

Applicant Name(s): _____

Are you currently licensed by OCS as a foster parent? Yes No
Have you been licensed by DFYS/OCS as a foster Parent? Yes No
If yes, where, _____ when _____

Do you now or have you ever provided care to non related adults or children? Yes No

If yes, where, _____ when _____ and what type _____

Was any care certificate or license you have ever held been denied, suspended, revoked, withdrawn, or relinquished? Yes No

Have you previously applied to DFYS/OCS for placement of a child? Yes No

Type	DFYS/OCS Office	Application Date	Date Study Completed	Approved
<input type="checkbox"/> Relative Care	_____	_____	_____	_____
<input type="checkbox"/> Foster Care	_____	_____	_____	_____
<input type="checkbox"/> Adoption	_____	_____	_____	_____
<input type="checkbox"/> Guardianship	_____	_____	_____	_____

Have you ever applied to another state, county, or private agency for placement of a child? Yes No

Agency Name _____ Address _____

Relative Care _____
 Foster Care _____
 Adoption _____
 Guardianship _____

Residential History

How long have you been at your current address? _____
If less than 5 years, list addresses for the past 5 years in the spaces below.

Street address	City	State	Zip

Closest schools:

Applicant 1 **References** (neighbors, employer, physician, friend) One reference may be related to applicant.

Name Mailing Address Zip Phone E-Mail Address

1. _____
2. _____
3. _____
4. _____

Applicant 2 **References** (neighbors, employer, physician, friend) One reference may be related to applicant.

Name Mailing Address Zip Phone E-Mail Address

- 1 _____
- 2 _____
- 3 _____

Applicant Name(s): _____

A Complete Application Must Include:

- Completed Application for Therapeutic Foster Parent(s)
- Completed Background Information Foster Parent for each applicant
- Completed Pant for Foster Care
- Completed Clearance for Licensing form for each applicant and household member 16 years of age or older
- Completed Application for Background Check
- Two fingerprint card for each applicant and household member 16 years of age or older

Applicant Certification and Signature

I (we) have read and completed this application

I (we) certify that this information and any information given at a later date will be true, complete and accurate.

I (we) will provide fingerprint cards within 10 days of notification of receipt of a provisional clearance from the state's Background Check Unit

Applicant 1 Signature**Date****Applicant 2 Signature****Date****For CCS Use Only**

Application initially received on:

Date: _____

Application accepted as complete with all documentation on:

Date: _____

Application reviewed and accepted by: _____

Staff Signature

Date: _____

Personal contact and interview with prospective Therapeutic Foster Parents scheduled.

Staff Signature

Date: _____