

PROSPECTIVE FOSTER OR ADOPTIVE PARENT APPLICATION



Instructions: Please fully complete the application to the best of your ability. If you have questions, please do not hesitate to call us, and we will assist you in this process. For questions that do not apply to you, your home or family, please note or mark N/A.

I/We are interested in:	<input type="checkbox"/> Foster Care	<input type="checkbox"/> Foster to Adopt	<input type="checkbox"/> Adoption	<input type="checkbox"/> Kinship
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HOME ADDRESS OF APPLICANT(S)

Current Street Address:		
City:	Zip Code:	County:

APPLICANT'S IDENTIFYING AND CONTACT INFORMATION

APPLICANT # 1	Full Name (First, Middle, Last):	
	Other Last Names Used:	
	Other First Names Used (nicknames):	
	Date of Birth: / /	Social Security #: - -
	Current Age:	Driver's License #:
	Cell Phone: - -	Work Phone: - -
	E-mail:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other	
	Place of Birth (City, State, Country):	
	Race:	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

APPLICANT # 2	Full Name (First, Middle, Last):	
	Other Last Names Used:	
	Other First Names Used (nicknames):	
	Date of Birth: / /	Social Security #: - -
	Current Age:	Driver's License #:
	Cell Phone: - -	Work Phone: - -
	E-mail:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other	
	Place of Birth (City, State, Country):	
	Race:	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

HOUSEHOLD MEMBER INFORMATION – MINOR CHILDREN

(Please list ALL full and/or part-time minor children living in the household)

N/A (not applicable, there are no minor children living in the home).

CHILD #1	Full Name (First, Middle, Last):		
	Date of Birth: / /	Social Security #: - -	
	Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		

CHILD #2	Full Name (First, Middle, Last):		
	Date of Birth: / /	Social Security #: - -	
	Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		

CHILD #3	Full Name (First, Middle, Last):		
	Date of Birth: / /	Social Security #: - -	
	Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		

CHILD #4	Full Name (First, Middle, Last):		
	Date of Birth: / /	Social Security #: - -	
	Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		

CHILD #5	Full Name (First, Middle, Last):		
	Date of Birth: / /	Social Security #: - -	
	Age:	Grade:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adopted <input type="checkbox"/> Other:		

Is DFPS the managing conservator of any of the children listed above?: No Yes

If yes, which children:

Date Child(ren) Were Placed In Your Home: / /

Name of DFPS Kinship Worker:

Kinship Worker's Phone #: - -

HOUSEHOLD MEMBER INFORMATION – ADULTS

(Excluding applicants, Please list ALL full and/or part-time adults living in the household)

N/A (not applicable, there are no other adults living in the home).

ADULT #1	Full Name (First, Middle, Last):	
	Other Names Used:	
	Cell Phone: - -	Work Phone: - -
	Date of Birth: / /	Social Security #: - -
	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Time Spent in Home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other:	
	Role in Home: <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Works <input type="checkbox"/> Other:	
	Will this Person be a Caregiver for Children?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to Applicant #1: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
	Relation to Applicant #2: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	

ADULT #2	Full Name (First, Middle, Last):	
	Other Names Used:	
	Cell Phone: - -	Work Phone: - -
	Date of Birth: / /	Social Security #: - -
	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Time Spent in Home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other:	
	Role in Home: <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Works <input type="checkbox"/> Other:	
	Will this Person be a Caregiver for Children?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to Applicant #1: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
	Relation to Applicant #2: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	

ADULT #3	Full Name (First, Middle, Last):	
	Other Names Used:	
	Cell Phone: - -	Work Phone: - -
	Date of Birth: / /	Social Security #: - -
	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Time Spent in Home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other:	
	Role in Home: <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Works <input type="checkbox"/> Other:	
	Will this Person be a Caregiver for Children?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Relation to Applicant #1: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
	Relation to Applicant #2: <input type="checkbox"/> Adult Child <input type="checkbox"/> Parent <input type="checkbox"/> Other:	

I have attached an additional sheet to add additional Adult household members.

MINOR & ADULT CHILDREN NOT LIVING IN THE HOME
 (Please list ALL biological, adopted or deceased children NOT living in the home)

N/A (I/we do not have any biological, adopted or deceased children not living in the home).

CHILD #1	Full Name (First, Middle, Last):		
	Street Address:		
	City:	State:	Zip Code:
	Cell Phone: - -	E-Mail:	
	Date of Birth: / /	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		

CHILD #2	Full Name (First, Middle, Last):		
	Street Address:		
	City:	State:	Zip Code:
	Cell Phone: - -	E-Mail:	
	Date of Birth: / /	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		

CHILD #3	Full Name (First, Middle, Last):		
	Street Address:		
	City:	State:	Zip Code:
	Cell Phone: - -	E-Mail:	
	Date of Birth: / /	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		

CHILD #4	Full Name (First, Middle, Last):		
	Street Address:		
	City:	State:	Zip Code:
	Cell Phone: - -	E-Mail:	
	Date of Birth: / /	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Relation to Applicant #1: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		
	Relation to Applicant #2: <input type="checkbox"/> Minor/Adult Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other:		

I have attached an additional sheet to add additional Adult/Minor children not living in the home.

HOUSEHOLD PETS

N/A (not applicable, there are no indoor or outdoor pets kept in the home or on the property).

PET #1	Pet Name:	Breed:
	Type of Pet: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Ferret <input type="checkbox"/> Other:	
PET #2	Pet Name:	Breed:
	Type of Pet: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Ferret <input type="checkbox"/> Other:	
PET #3	Pet Name:	Breed:
	Type of Pet: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Ferret <input type="checkbox"/> Other:	
PET #4	Pet Name:	Breed:
	Type of Pet: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Ferret <input type="checkbox"/> Other:	
PET #5	Pet Name:	Breed:
	Type of Pet: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Ferret <input type="checkbox"/> Other:	

Note: You must provide copies of current rabies vaccination for all dogs, cats and ferrets and must ensure rabies vaccination is kept up to date once licensed.

I have attached an additional sheet to add additional pets living in the home or outdoors on the property.

HOME AND COMMUNITY INFORMATION

Home Description	Type of Housing: <input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Manufactured <input type="checkbox"/> Other:		
	Home Location: <input type="checkbox"/> Neighborhood <input type="checkbox"/> Rural <input type="checkbox"/> Other		Housing Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent
	Number of Bedrooms:	Number Bathrooms:	Number of Stories:
	Number of Bedrooms for Foster/Adopt Children:		Home Square Foot:
	Type of Water Service: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Well		Age of Property:
	Type of Heating/Cooling Utilities in Home: <input type="checkbox"/> Electric <input type="checkbox"/> Gas <input type="checkbox"/> Combination		

Note: You will need to provide a floor plan for your home that includes dimensions for all bedrooms and common rooms/areas. This plan must show all doors and windows.

Home and Community Services	Emergency Services Provided By: <input type="checkbox"/> City Police Dept. <input type="checkbox"/> County Sherriff's Dept.	
	Nearest Hospital to Home Address:	
	Parks Near Home:	
	Elementary School:	Grade: Kindergarten -
	Middle School:	Grade: -
	Junior High School:	Grade: -
	High School:	Grade: -

Note: Please fully complete all of the information above (i.e. If you plan to serve kids 0 – 3 please complete school information for all grades even though you do not wish to serve school age children).

TRANSPORTATION

Do you have Liability and Personal Injury Protection Insurance on <u>all</u> vehicles that will be or could be used to transport children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing to transport children placed in your home to doctor and therapy appointments, school activities, weekly or bi-weekly visits with biological parents and/or siblings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have appropriate passenger restraint systems for the age of child(ren) you wish to serve (i.e. infant car seat, toddler car seat, booster seat)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

***Note:** You will need to have an appropriate passenger restraint system for the age of child you are wanting to serve prior to the child's placement into your home. If you are looking to serve children in a range of ages (i.e. 0 to 5) it is recommended you buy a "convertible" type car seat that can accommodate infants and toddlers.*

VEHICLE INFORMATION

Please list all vehicles that will be involved in transportation of foster or adoptive children:

YEAR	MAKE:	MODEL:	TOTAL # SEATS	CURRENT STATE INSPECTION	CURRENT REGISTRATION
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT EDUCATION INFORMATION

***Note:** You will need to provide a copy of your transcripts or diploma for your highest level of education obtained.*

Please complete for each applicant.	Applicant # 1	Applicant # 2
Highest level of education obtained:	<input type="checkbox"/> Grade <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> Trade School <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree	<input type="checkbox"/> Grade <input type="checkbox"/> GED <input type="checkbox"/> High School <input type="checkbox"/> Trade School <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree

HIGH SCHOOL	Applicant # 1	Applicant # 2
Name of High School Attended:		
City, State of High School:		
Did you Graduate High School:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of High School Graduation:	/ / or <input type="checkbox"/> N/A	/ / or <input type="checkbox"/> N/A

APPLICANT EDUCATION INFORMATION (Cont.)

Please complete College/ Trade School Information Below for each applicant.	Applicant # 1	Applicant #2
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COLLEGE OR TRADE SCHOOL ATTENDED		
Name of College Attended:		
City, State of College:		
Did you Graduate?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degree Obtained:		
Date of College Graduation:	/ / or <input type="checkbox"/> N/A	/ / or <input type="checkbox"/> N/A

COLLEGE OR TRADE SCHOOL ATTENDED		
Name of College Attended:		
City, State of College:		
Did you Graduate?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Degree Obtained:		
Date of College Graduation:	/ / or <input type="checkbox"/> N/A	/ / or <input type="checkbox"/> N/A

I have attached an additional sheet to add additional Colleges attended and/or Degrees earned.

APPLICANT EMPLOYMENT INFORMATION

Please complete Employment Information Below for each applicant.	Applicant # 1	Applicant #2
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CURRENT EMPLOYMENT / OCCUPATION		
Current Occupation:		
Current Employer Name:		
City, State of Employer:		
Employer Phone:	- -	- -
Length of Time on Job (Yrs./Months):	yrs. / mos.	yrs. / mos.
Full Time or Part Time?:	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Days & Hours Worked:		

PREVIOUS EMPLOYMENT / OCCUPATION		
Previous Occupation:		
Previous Employer Name:		
City, State of Employer:		
Employer Phone:	- -	- -
Length of Time on Job:	yrs. / mos.	yrs. / mos.

Note: We must have at least a 5-year work history for each applicant. If at current and previous employers for less than 5 years please attach a separate sheet of paper detailing all employers for the past 5 years.

I have attached an additional sheet to add additional pets living in the home or outdoors on the property.

INCOME INFORMATION

Note: Only include income from sources that consistently contribute to household monthly expenses. You will need to provide proof (at least 2 months statements or stubs/receipts) of all income contributing to household expenses (see budget section below). You must also provide an itemized copy of each applicant's bank statements for the two months prior to your home being licensed!

Please complete Employment Income Information Below for each applicant.	Applicant # 1	Applicant # 2
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APPLICANT EMPLOYMENT INCOME RECEIVED		
Employment Income – Annual Gross (Income received from current employer <u>before taxes or other deductions</u> each year)	\$ Annual Gross <input type="checkbox"/> N/A	\$ Annual Gross <input type="checkbox"/> N/A
Employment Income – Net Monthly (Income received from current employer monthly and after <u>ANY and ALL</u> deductions)	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A

Please complete all other household income sources.	Applicant # 1	Applicant # 2	Household Member
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OTHER HOUSEHOLD INCOME RECEIVED			
Employment Income for Adult Household Members			\$ Annual Gross \$ Net Monthly <input type="checkbox"/> N/A
Unemployment Income	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Retirement, Pension or Lump Sum Distribution	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Social Security Income (SSI)	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Social Security Disability Income (SSDI)	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Rental Home/Property Income	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Cash Income	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Food Stamps	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Temporary Aid to Needy Families (TANF)	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A
Other Income (not noted above)	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A	\$ Net Monthly <input type="checkbox"/> N/A

If you listed any income above please provide a detailed explanation of each source and amount (i.e. if a household member receives SSDI provide reason and household member name; if you receive rental property income note if you own the property, if the property is mortgaged, number of properties owned, etc.):

BUDGET - MONTHLY EXPENSE INFORMATION

Note: Please make sure to note something for each category listed (mark N/A if the expense is not applicable to your household). Additionally, please make sure you are putting accurate average amounts (i.e. if you have pets do not put \$0.00 for pet expenses, instead estimate food, veterinary, etc. costs).

Please complete the following Budget Information for your household.	Not Applicable	Average Monthly Amount
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Housing		
Mortgage Payment Included <input type="checkbox"/> Insurance Included <input type="checkbox"/> Property Taxes	<input type="checkbox"/> N/A	\$
Rent Payment	<input type="checkbox"/> N/A	\$
Property Taxes <i>(if not included in mortgage payment escrow)</i>	<input type="checkbox"/> N/A	\$

Utilities		
Electric/Gas <input type="checkbox"/> Included in Rent	<input type="checkbox"/> N/A	\$
Water/Garbage/Sewer <input type="checkbox"/> Included in Rent	<input type="checkbox"/> N/A	\$
Phone <i>(home)</i>	<input type="checkbox"/> N/A	\$
Internet	<input type="checkbox"/> N/A	\$
Cable/Satellite/TV	<input type="checkbox"/> N/A	\$

Insurance		
Homeowners Insurance <i>(if not included in mortgage payment escrow)</i>	<input type="checkbox"/> N/A	\$
Renters Insurance	<input type="checkbox"/> N/A	\$
Life Insurance	<input type="checkbox"/> N/A	\$
Vehicle Insurance	<input type="checkbox"/> N/A	\$
Medical/Dental/Eye Insurance <input type="checkbox"/> Deducted from Employer	<input type="checkbox"/> N/A	\$

Debts		
Child/Spousal Support Payments	<input type="checkbox"/> N/A	\$
Student Loans <i>(minimum monthly payments)</i>	<input type="checkbox"/> N/A	\$
Credit Cards <i>(minimum monthly payments)</i>	<input type="checkbox"/> N/A	\$
Car Payments	<input type="checkbox"/> N/A	\$
Other Loan Accounts <i>(Store Financed, Title Loans, Payday Loans)</i>	<input type="checkbox"/> N/A	\$
Other Debts <i>(other real property, medical, etc. explain below)</i>	<input type="checkbox"/> N/A	\$

Other Personal Expenses		
Hair Cut, Personal Grooming	<input type="checkbox"/> N/A	\$
Medical Co-Pays/Co-Insurance/Other Medical Items/Supplies Not Covered	<input type="checkbox"/> N/A	\$
Clothing <i>(including coats, shoes, seasonal items)</i>	<input type="checkbox"/> N/A	\$
Medication <i>(over the counter, prescription co-pays, etc.)</i>	<input type="checkbox"/> N/A	\$

Food		
Groceries <i>(do not include eating out expenses or household items below)</i>	<input type="checkbox"/> N/A	\$
Eating Out <i>(restaurant, take-out, snacks, etc.)</i>	<input type="checkbox"/> N/A	\$

BUDGET - MONTHLY EXPENSE INFORMATION (Cont.)

Other Household Expenses		
Cell Phones	<input type="checkbox"/> N/A	\$
Subscriptions (<i>magazine, internet, book, movie, music, etc.</i>)	<input type="checkbox"/> N/A	\$
Storage Units/Spaces	<input type="checkbox"/> N/A	\$
Vehicle Maintenance (<i>oil changes, repairs</i>)	<input type="checkbox"/> N/A	\$
Vehicle Fuel (<i>gas</i>)	<input type="checkbox"/> N/A	\$
Household Items (<i>laundry soap, cleaning supplies, paper items, , hygiene products, filters, etc.</i>)	<input type="checkbox"/> N/A	\$
Childcare Expense	<input type="checkbox"/> N/A	\$
Family Recreation (<i>sports fees, athletic club membership fees, etc.</i>)	<input type="checkbox"/> N/A	\$
Pet Supplies, Food and Care	<input type="checkbox"/> N/A	\$
Family Entertainment (<i>concerts, movies, etc.</i>)	<input type="checkbox"/> N/A	\$
Hobbies and Interests (<i>hobby/club fees, crafts, entry fees, etc.</i>)	<input type="checkbox"/> N/A	\$
Other Expenses Not Listed Above (<i>please describe below</i>)	<input type="checkbox"/> N/A	\$

If you listed any other expenses above, please describe:

MARRIAGES / SIGNIFICANT PREVIOUS RELATIONSHIPS

Note: You will need to provide a copy of your marriage license and death certificate or divorce decree for any previous marriages (as applicable).

CURRENT Marriage or Relationship Status (Applicant #1 and #2)

Please check the box best describing your current relationship status.	<input type="checkbox"/> Single	Are you currently dating? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Who:
	<input type="checkbox"/> Widowed	Name of Former Spouse: Date of Marriage: / / Are you currently dating? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death: / / Cause of Death: If Yes, Who:
	<input type="checkbox"/> Engaged	Date Began Dating: / /	Date of Future Marriage: / /
	<input type="checkbox"/> Married	Date of Marriage: / /	County of Marriage: State of Marriage:

Previous Marriages and/or Significant Relationships	Applicant #1	Applicant #2
Please list the number of previous marriages for each applicant:		
Please list the number of significant relationships (not resulting in marriage) for each applicant (include all significant relationships and all relationships resulting in birth of a child):		

Please complete the following information for previous marriages.	Applicant #1	Applicant #2
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Previous Marriage #1		Relationship Applies To:	
Name of Former Spouse:			
Date of Marriage:	/ /		
County and State of Marriage:		<input type="checkbox"/>	<input type="checkbox"/>
Date of Divorce or Death:	/ /		
County and State of Divorce or Death:			
Reason for Divorce or Death (if applicable):			

Previous Marriage #2		Relationship Applies To:	
Name of Former Spouse:			
Date of Marriage:	/ /		
County and State of Marriage:		<input type="checkbox"/>	<input type="checkbox"/>
Date of Divorce or Death:	/ /		
County and State of Divorce or Death:			
Reason for Divorce or Death (if applicable):			

Previous Marriage #3		Relationship Applies To:	
Name of Former Spouse:			
Date of Marriage:	/ /		
County and State of Marriage:		<input type="checkbox"/>	<input type="checkbox"/>
Date of Divorce or Death:	/ /		
County and State of Divorce or Death:			
Reason for Divorce or Death (if applicable):			

Previous Marriage #4		Relationship Applies To:	
Name of Former Spouse:			
Date of Marriage:	/ /		
County and State of Marriage:		<input type="checkbox"/>	<input type="checkbox"/>
Date of Divorce or Death:	/ /		
County and State of Divorce or Death:			
Reason for Divorce or Death (if applicable):			

I have attached an additional sheet to add additional previous marriages.

RESIDENCE HISTORY (Past 10 Years)

Please list all previous addresses for the past 10 Years for each Applicant.			Applicant #1	Applicant #2
Address, City, State, Zip Code	Dates at Address (Month-Year)	Time at Address	Address Applies to Applicants Checked	
Current Address (as noted on page 1)	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>
	-	yrs. mo.	<input type="checkbox"/>	<input type="checkbox"/>

MILITARY SERVICE

Applicant's Previous Military Service	Applicant #1	Applicant #2
Have you ever served in the military?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Branch Served In:		
If Yes, Dates of Service (Month / Year):	/	/
If Yes, Type of Discharge (or note "Active"):		

RELIGIOUS AFFILIATION

Applicant's Religious Affiliation	Applicant #1	Applicant #2
Do you have a religious affiliation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Religion / Denomination:		
If Yes, Church Name:	/	/
If Yes, Church City and State:		
If Yes, Number of Years Attended:		
If Yes, Frequency Attended:	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Sporadic	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Sporadic

Are you willing to serve children who are of the same religion but a different demonization (take them to the denomination of their or their parents choice)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing to serve children of a different religion (take them to religious services of their or their parents choice)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any religious beliefs that would prevent you from providing <u>any</u> type of medical care to a child placed in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing to serve a child who does not have any religious affiliation and whom does not wish to attend religious services (i.e. have a plan for care while you attend services)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH STATUS

Applicant's Health Status	Applicant #1	Applicant #2
1. Have you <u>ever tested positive</u> for TB (tuberculous) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you <u>ever been diagnosed</u> with a Sleep Disorder ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you <u>ever been diagnosed</u> with any type of Hepatitis ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you <u>ever been diagnosed</u> with any type of Cancer ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you <u>ever been diagnosed</u> with Type I or Type II Diabetes ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you <u>ever been diagnosed</u> with a Heart Disorder (or disease) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you <u>ever been diagnosed</u> with High Blood Pressure ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you <u>ever been diagnosed</u> with Fainting Spells or Seizures ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you <u>ever been diagnosed</u> with any Lung, Kidney or other Organ Disorder ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you <u>ever been diagnosed</u> with a Vision or Hearing Disorder ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you <u>ever been diagnosed</u> with an Autoimmune Disorder (including but not limited to Lupus, HIV/AIDS, Graves' Disease, Gillian-Barr Syndrome, Hashimoto's, Multiple Sclerosis, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you <u>ever been diagnosed</u> with any type of Physical Disability ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you <u>ever been diagnosed</u> with any type of Mental Disability ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you <u>ever been diagnosed</u> with any type Fertility Issue ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you <u>ever had</u> an Organ Transplant ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Have you <u>ever had</u> a Heart Attack, a Heart Blockage, Heart Surgery ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you <u>ever had</u> Surgery for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Are you <u>currently on</u> an Organ Transplant waiting list?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Have you <u>ever attended</u> Counseling Services for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Have you <u>ever been admitted for or received outpatient</u> Psychiatric Treatment ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have you <u>ever been prescribed</u> Psychotropic Medication (anti-depressants, anti-psychotics etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Are you <u>currently</u> Disabled in any way (limited mobility, require walking / other living aids)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to any of the above please give a detailed explanation (including year of diagnosis, if previous or current diagnosis, current prognosis (per physician), current medication(s), effectiveness of current medication(s), long-term prognosis, related side effects (of diagnosis or related medications(s), etc.):

HEALTH STATUS (Cont.)

Applicant's Health Status (Continued)	Applicant #1	Applicant #2
Are you <u>currently</u> prescribed any medications ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you <u>currently</u> take any over the counter medications ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If you answered "Yes" to currently taking or being prescribed any medications, please give a detailed explanation (including medication name, frequency of dose, reason for medication (symptoms or diagnosis medication is prescribed to treat), length of time on medication and description of medication effectiveness.); use a separate sheet if needed:</p>		

EMERGENCY SERVICES AND CALLS

Note: An Open Records Request for emergency/disturbance calls will be submitted to your local/county police department for any address at which you have lived in the previous 2 years as required by Minimum Standards.

If you have an emergency requiring police or paramedic response, does the city police department, county sheriff's department or both respond to your current home address?	<input type="checkbox"/> City P.D. <input type="checkbox"/> County Sheriff <input type="checkbox"/> Both
In the past 2 years, have you called 911 for a medical emergency at your home address?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 2 years, have you called 911 or have the police responded to your home address due to a domestic violence or disturbance complaint?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 2 years, has your city Police Department or County Sheriff's Department responded to your home address for any other reason not noted above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If you answered, "Yes" to <u>any</u> of the above please give a detailed explanation including dates, circumstances and outcome of each call or response:</p>	

CRIMINAL HISTORY

Note: All foster/adoptive parents and any household member age 14 and over must submit to a complete criminal history, Central Registry and FBI fingerprint check.

Please answer each question below for each applicant and household members 14+ yrs.	Applicant # 1	Applicant #2	Household Member
Have you lived outside of the State of Texas in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A
Have you ever been charged, arrested, and/or convicted of a misdemeanor or felony, including domestic violence disturbance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A
Have you ever had any allegations, charges, or convictions again you for Child Abuse or Neglect?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A

Please answer each question below for each applicant and household members 14+ yrs.	Applicant # 1	Applicant #2	Household Member
Have any of your children been temporarily or permanently removed from your home by the courts or Child Protective Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A
Are you currently on probation or parole?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A
Are you willing to submit to a complete criminal history check including Central Registry and FBI fingerprint check?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No N/A

If you answered, "Yes" to any of the above please give a detailed explanation including dates, circumstances and outcome of each (use a separate sheet if needed):

PREVIOUS LICENSING/AGENCY INFORMATION

Is <u>either</u> applicant CURRENTLY LICENSED with another Child Placing Agency to provide foster or adoptive children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has either applicant EVER been PREVIOUSLY LICENSED by another Child Placing Agency to provide foster or adoptive care to children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has <u>either</u> applicant EVER APPLIED to another Child Placing Agency to provide foster or adoptive care to children and been DENIED licensure by the agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered, "YES" to any of the items above please fully complete the information below:

Previous Agency Information <i>(Please list most recent agency 1st)</i>			
Agency #1	Agency Status: <input type="checkbox"/> Previously Applied and Denied <input type="checkbox"/> Previously Licensed <input type="checkbox"/> Currently Licensed		
	Which Applicants Does This Agency Apply To?: <input type="checkbox"/> Applicant #1 <input type="checkbox"/> Applicant #2 <input type="checkbox"/> Both		
	Agency Name:	Agency Phone:	
	Agency Address:		
	City:	State:	Zip Code:
	Date Initially Licensed: _____ or <input type="checkbox"/> N/A	Current Investigation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date Closed: _____ or <input type="checkbox"/> N/A	Date Denied: _____ or <input type="checkbox"/> N/A	
	If Applicable, Reason for Denial or Closure (attach copy of denial or closure letter):		
	If Applicable, Reason for Wanting to Transfer Agencies:		

Previous Agency Information

Agency #2	Agency Status: <input type="checkbox"/> Previously Applied and Denied <input type="checkbox"/> Previously Licensed <input type="checkbox"/> Currently Licensed		
	Which Applicants Does This Agency Apply To?: <input type="checkbox"/> Applicant #1 <input type="checkbox"/> Applicant #2 <input type="checkbox"/> Both		
	Agency Name:		Agency Phone:
	Agency Address:		
	City:	State:	Zip Code:
	Date Initially Licensed: or <input type="checkbox"/> N/A		Current Investigation: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date Closed: or <input type="checkbox"/> N/A		Date Denied: or <input type="checkbox"/> N/A
	If Applicable, Reason for Denial or Closure (attach copy of denial or closure letter):		
	If Applicable, Reason for Wanting to Transfer Agencies:		

If more than 2 Agencies, please use a separate sheet of paper to list ALL others.

I have attached an additional sheet to add additional Agencies previously licensed with or applied to.

REFERENCES AND/OR INTERVIEWS

For EACH applicant, please list three (3) individuals whom we may contact for a reference who have **known you for a minimum of 3 years** and who are well acquainted with you and/or your family. It is important for all information to be complete. If you are a married couple applying, please ensure you include references from EACH spouse as indicated below.

TWO references **MUST** be **COMMUNITY REFERENCES** (such as clergy, neighbor, school personnel, co-worker or other community type person). Please do not list friends or relatives in the community reference section.

ONE reference **MUST** be your **NEAREST RELATIVE** (i.e. mother, father, brother, sister, etc.)

APPLICANT #1 REFERENCES			
NEAREST RELATIVE	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:
COMMUNITY REFERENCE #1	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:

COMMUNITY REFERENCE #2	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:

APPLICANT #2 REFERENCES

NEAREST RELATIVE	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:

COMMUNITY REFERENCE #1	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:

COMMUNITY REFERENCE #2	Name:		Relationship:
	Address:		
	City:	State:	Zip Code:
	Phone Number 1:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Phone Number 2:		Phone Type: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	E-mail Address:		# Years Known:

OTHER INFORMATION

Is there any other information you feel the Giocosa Foundation should consider in reviewing your application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If "Yes", Please explain:

AFFIRMATION AND ACKNOWLEDGEMENT

I hereby declare that the information provided by me in this Application for Foster Care and Adoption is true, accurate and complete to the best of my knowledge. I give my permission for any of this information to be verified. I give my consent for any agency, employers, company, friends, or family to be contacted.

I acknowledge my understanding that the Giocosa Foundation reserves the right to decline any Prospective Foster or Adoptive Parent(s) during ANY part of the licensing process. I also understand that I may decide not to continue with the process at ANY time during the licensing process.

Applicant #1 Printed Name

Signature

Date

Applicant #2 Printed Name

Signature

Date

Please return the completed Application to the nearest Giocosa Foundation Office via mail. If you would like to e-mail your application please call your local Giocosa office and ask for the foster home development specialist's contact information.

BEDFORD (DFW) OFFICE

1909 Central Drive, Ste. 305
Bedford, TX 76021
817-545-5300 (o)
817-5455305 (f)

BELTON OFFICE

204 N East St, Ste. A1
Belton, TX 76513
254-613-4501 (o)
254-613-4570 (f)

BROWNSVILLE OFFICE

1805 Ruben Torres Blvd., Ste. B1
Brownsville, TX 78521
956-621-0727 (o)
956-621-0733 (f)

HOUSTON OFFICE

6104 Westline Drive
Houston, TX 77036
713-647-6691 (o)
713-636-9098 (f)

HUTTO OFFICE

204 N East St, Ste. A1
Belton, TX 76513
254-613-4501 (o)
254-613-4570 (f)

LAREDO OFFICE

201 W Hillside, Ste. 13
Laredo, TX 78041
956-568-7597 (o)
956-568-7605 (f)

If you are not sure which office would serve your area, please return to the Administrative Offices:

ADMINISTRATIVE OFFICE

201 N FM 1660
Hutto, TX 78634
512-306-9241 (o)
512-306-9242 (f)