

**Prospective Caregiver Application** *Thank you for your interest in being a resource for children and families.*

Primary Caregiver: \_\_\_\_\_

Secondary Caregiver (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Primary Email: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_ Secondary Email: \_\_\_\_\_

To which program are you applying?

- Partnership Parenting       Resource Parenting       Adoption Legal Risk       Adoption  
 Relative Partnership Parenting       Respite Family       Undecided About Previous Options  
 Volunteer Only       I do not wish to apply

Why is now a good time for your family to foster / adopt?

\_\_\_\_\_  
\_\_\_\_\_

Have you fostered or adopted in the past?     No     Yes (If yes, where and when?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you currently approved with an agency?     No     Yes (If yes, which agency?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Marital Status

- Single     Co-habiting     Married (If married, please provide date and location of marriage)

Date married: \_\_\_\_\_ Location: \_\_\_\_\_

**Primary Caregiver identifying information**

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

- Race / Ethnicity:     White     Hispanic or Latino     Black or African American  
 Asian / Pacific Islander     Other (Specify):     Native American or American Indian

Primary Caregiver identifying information continued next page

Highest level of education: \_\_\_\_\_ Languages spoken: \_\_\_\_\_

Have you lived in any other state in the past five years?  No  Yes (If yes, please list states below)

List any previous marriages. Include dates and how the marriage ended:

### Primary Caregiver employment information

Primary Caregiver's occupation: \_\_\_\_\_ Length of time employed: \_\_\_\_\_

Annual income: \_\_\_\_\_

### Secondary Caregiver identifying information

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Race / Ethnicity:

White  Hispanic or Latino  Black or African American  Native American or American Indian

Asian / Pacific Islander  Other (Specify): \_\_\_\_\_

Highest level of education: \_\_\_\_\_ Languages spoken: \_\_\_\_\_

Have you lived in any other state in the past five years?  Yes  No Yes (If yes, please list states below)

List any previous marriages. Include dates and how the marriage ended.

### Secondary caregiver employment information (if applicable):

Secondary Caregiver's occupation: \_\_\_\_\_ Length of time employed: \_\_\_\_\_

Annual income: \_\_\_\_\_

### CPR Certification

Primary Caregiver: Do you have current CPR / First Aid Certification?  Yes  No

Expiration date (if you have a current Certification): \_\_\_\_\_

Secondary Caregiver: Do you have current CPR / First Aid Certification?  Yes  No

Expiration date (if you have a current Certification): \_\_\_\_\_

## Other household members

Please complete the following information for any persons 18 or older residing in your home.

Background checks are conducted on all adults living in the home.

Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Race / Ethnicity:

White  Hispanic or Latino  Black or African American  Native American or American Indian

Asian / Pacific Islander  Other (Specify): \_\_\_\_\_

Languages spoken: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date married (if applicable): \_\_\_\_\_

Role in home: \_\_\_\_\_

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Name: \_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Race / Ethnicity:

White  Hispanic or Latino  Black or African American  Native American or American Indian

Asian / Pacific Islander  Other (Specify): \_\_\_\_\_

Languages spoken: \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date married (if applicable): \_\_\_\_\_

Role in home: \_\_\_\_\_

Do you operate a home-based business?  Yes  No      Do clients regularly visit?  Yes  No  N/A

Do you have, or plan to acquire, a child care license?  Yes  No

Do you operate a licensed personal care home?  Yes  No

**Children**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Grade: \_\_\_\_\_

List the names of your children (biological or other),  
minor or adult, not residing in home.

And if they visit your home, how often?

_____	_____
_____	_____
_____	_____

What are the best days / times to contact you?

\_\_\_\_\_

What are the best days / times for home visits?

\_\_\_\_\_

What days / times are you available for pre-service training?

\_\_\_\_\_

Use the space below to provide any comments, questions or additional household member information.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Primary Caregiver Signature

Date

Secondary Caregiver Signature

Date



Department of Human Services/Office of Inspector General

LIVE SCAN APPLICATION FORM  
 AUTHORIZED SIGNATURES ARE REQUIRED  
 APPLICANT MUST PRESENT VALID GOVERNMENT-ISSUED PHOTO ID

To be completed by Electronic Fingerprint Technician			
Date Received:		OIG EFT Office:	
Form of I.D. Presented:		Live Scan Date:	
ORI Number Used:		EFT Signature:	

To be completed by DHS Authorized Official	To be completed by Applicant (PLEASE PRINT)			
Date of Request:		<b>LAST NAME</b>	<b>FIRST</b>	<b>MIDDLE INITIAL</b>
DFCS Case Number:				
Impact Request Number:		Address 1:		
Child Placement Requesting DFCS Office:				
Authorizing Authority (Print):		Address 2:		
Authorizing Authority <b>Signature</b> :		City:		
Authorizing Authority Email Address:		County:		
Purchase Order number:		State:	Zip Code:	
County to Charge/Finance Code:		Telephone:		
Point of Contact:		U.S. Citizen: YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>ONLY ONE (1) REASON CAN BE CHOSEN:</b>  <b>DFCS:</b> <input type="checkbox"/> Foster <input type="checkbox"/> Adopt <input type="checkbox"/> CPS Investigation <input type="checkbox"/> 5 Year Foster Renewal <input type="checkbox"/> Child Care-Volunteer <input type="checkbox"/> Purpose Code X (Approval from CJIS On-Call Team)		If <b>NO</b> , country of citizenship:		
		Social Security #:		
		Date of Birth:		
		Place of Birth (STATE or COUNTRY):		
		Race:	Sex:	
	Height:	Weight:		
	Eye Color:	Hair Color:		
<b>Comments:</b>	<input type="checkbox"/> I understand and have been informed that an FBI/NCIC and GBI/GCIC background check will be conducted. <input type="checkbox"/> I have been provided written notice of the Applicants Privacy Rights and the Privacy Act Statement, Title 28 CFR 16.30 through 16.34. Signature _____ Date _____			
<b>Applicant Signature (Required):</b>	<b>Applicant Printed Name:</b>			