

FOSTER HOME STUDY REQUEST

Use of form: Notice to Applicant. Provision of information for completion of this form is voluntary; however, unless it is provided we cannot process your application for a foster home license or complete a Kinship Care Application. Personally identifying information requested on this form will only be used to perform criminal and child welfare background checks. Provision of your Social Security Number is voluntary; however, it is one of the unique identifiers used to prevent incorrect matches.

Placement Type (check one) <input type="checkbox"/> Emergency - Non-Relative <input type="checkbox"/> Relative - Relationship:		
Name - Assigned Worker		Telephone Number
SIGNATURE - Supervisor of Referring Worker	Site	Date Signed

PROVIDER INFORMATION

Caregiver 1

Name (Last, First, MI)	Household Role	Birthdate	Social Security Number
			- -
Address (Street, City, State, Zip Code)			
Telephone Number - Home () -	Telephone Number - Work () -	Work Hours	

Caregiver 2

Name (Last, First, MI)	Household Role	Birthdate	Social Security Number
			- -
Address (Street, City, State, Zip Code)			
Telephone Number - Home () -	Telephone Number - Work () -	Work Hours	

Applicant's Own Children in Home

Name	Gender	Birthdate	Social Security Number
			- -
			- -
			- -

Others in Home (e.g., boarders, relatives)

Name	Gender	Birthdate	Social Security Number	Relationship
			- -	
			- -	
			- -	
			- -	

CHILD INFORMATION

Name - Child(ren) for which License Requested	Gender	Birthdate	Case Number	Relation to Applicant

Yes No Children are Currently in Caretaker's Home

If "Yes", indicate how long:

Reason for Foster Child Placement Outside of Own Family Home

Date - Home Visit

Number of Bedrooms in the Home

Describe Physical Condition of Home. (Home must be viewed by referring worker.)

Applicant's Verbal Statement to Worker Regarding His / Her:

Police Record

Physical Health / Mental Health

Previous Contact with Child Protective Services - Brief Explanation / Include Dates

Applicant's Child Protective Services Clearings - Dates

Yes No In making this referral, does Worker feels this is an appropriate placement?

LICENSING DECISION

eWiSACWIS Provider Number _____ Date - License Effective From _____ Date - License Effective To _____

SIGNATURES

_____ **SIGNATURE - Out of Home Care Worker** _____ **Date Signed** _____