Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear prospective foster/adoptive parent:

Thank you for your interest in Onondaga County’s Foster Care & Adoption program. Enclosed you will find an application along with additional information on foster parenting and adoption. You may return the completed application to us via, fax: at 315-435-3778 or mail.

Upon receipt and review of your applications and self- assessment we will make a follow-up phone call where we will review the self-assessment and further discuss any criminal or family court history, medical/mental health treatment, & pets in the home. We will review your financial situation specifically your monthly household income and expenses. This is done to ensure that families are not experiencing stressors that would negatively impact children placed in their home.

We hold periodic information meetings at local libraries that are required for you to attend if you choose to move forward in the process.

Please give us a call if you have any questions or would like to register for the information meeting at 315-435-3827.

Sincerely:

Foster/Adoptive Parent Intake Team

Onondaga County Department of Children & Family Services

**Local Children need you**

**Become a Foster/Adoptive Family today**

We are looking for dedicated families that are willing to share their lives, love and knowledge with children in need of a loving home. Becoming a foster/adoptive family in Onondaga County is one of the most challenging and rewarding ways to give back to our local community. We ask our families to work in partnership with the county toward the goal of one day reuniting children with their families.

Children of all ages come into care, but often our greatest need is finding families who are willing to accept sibling groups, pre-teens, teenagers, medically fragile infants and young children and homes willing to take care of a child when an emergency removal takes place**.** Children enter into our care for a variety of reasons-primarily due to a history of abuse and neglect. These children could greatly benefit from a supportive & caring home environment.

**The Certification Process:**

There are two main steps to becoming a certified foster/adoptive parent. To start, each family must be approved to attend the training. Once approved, both parents must then attend the training workshops, and complete a home study.

**Training Workshops**

There are foster parent training workshops that applicants must attend. The workshops are designed to educate potential foster/adoptive & relative families on meeting the needs of children in care, whilst still meeting the needs of your own household. Many of the trainings are accompanied by guest speakers. Currently, we run two training curriculums. One being a Kinship program where the family would be certified for a specific child or children already known to them. The other option would be traditional foster care/adoption wherein the family would accept a child from the community who does not have a resource already identified.

The speakers offer the opportunity to learn more about foster parenting from many local experts in the field of child welfare, including current foster families and even some children in care. We also require an online training “Supporting Normative Experiences for Children and Youth in Care. Applying the Reasonable and Prudent Parent Standard”. This training will help participants to understand the importance of allowing children in care to experience as many normative experiences as possible.

Our hope is to give our foster/adoptive families the knowledge and skills required to parent children in care. We do this through covering a variety of topics including child development, attachment, abuse & neglect, separation & loss, and more. We also go over our agency policies and expectations for foster homes in depth. The trainings will also cover the availability of community supports for foster parents to assist them in meeting the needs of children in care.

**Home Study**

During the training workshops your assigned Home Finder will visit you in your home.

Throughout these visits, we will discuss the goals of the agency as well as get to know you and your family.

We will also discuss the level of commitment expected from our foster parents. Our families find that they develop a strong connection with their Home Finder, who acts as their advocate.

As the certification progresses, we will begin contacting the personal references which you provide. You will also be asked a series of questions regarding your own personal health and emotional well-being. This information will be kept confidential.

**Home Expectations:**

* Each bedroom will have a door and a window.
* Children in care require their own bed.
* There can be up to three children per bedroom.
* Children in care cannot sleep in attics or unfinished basements.
* A safety and lead inspection must be completed.
* Non-familial boarders/renters are not permitted in foster/adoptive homes
* Foster homes will follow the policies, regulations, and guidelines set forth by Onondaga County.

**Certification:**

After you are certified, your decision to take a child into your home is based on shared information between you and your Home Finder. The length of a child’s placement depends on several varying circumstances.

**Supports to Available to Foster/Adoptive Parents:**

Let’s face it, caring for children is no easy task. We recognize this and offer a variety of assistance to our homes. To start, each foster home is assigned its own home finder to guide them through the home study and certification process. After certification, the home finder continues to provide ongoing support to the foster family by answering any questions that may arise and ensuring that the foster home is ready and willing to accept placements.

The county assists with transportation for foster children and by reimbursing foster homes for the care they provide to our children.

**Reimbursement:**

The cost of caring for a child is often a factor in a family’s decision to welcome a child into their home. Onondaga County provides reimbursement for a variety of expenses associated with raising a child, including the following:

* Daycare can be reimbursed for working parents.
* Children in Care receive medical benefits, as well a small amount for clothing reimbursement.
* Living expenses are reimbursed based on the age and need of the child(ren).

**Additional Supports**

Onondaga County is home to many child welfare resources outside of the Department of Children and Family Services:

There are numerous mental health clinics in the area that the caseworker can help coordinate services if need be.

The ENHANCE Clinic is a specialized health center for children in care. Onondaga County partners with the doctors and staff at ENHANCE to ensure that that all children are provided a continuity of care for the health services they receive while they are in the care of the county.

Family Place offers a simulated home environment for families to visit their children while they are in care. The staff at the Family Place often supervises visits to ensure they are conducted in a safe and productive manner.

**Thank you in advance for taking the time to consider this life changing commitment to the local children in need of a loving home.**

**Call Today 435-3827**

**Becoming a Foster Parent**

INTERESTED IN FOSTERING/ADOPTING?

CALL OR VISIT US TODAY! (315) 435-3827

**Frequently Asked Questions**

**WHAT ARE OUR NEEDS?**

We are looking for dedicated families that are willing to share their lives, love and knowledge with children in need of a loving home. Becoming a foster/adoptive family in Onondaga County is one of the most challenging and rewarding ways to give back to our local community. We ask our families to work in partnership with the county and birth parents toward the goal of one day reuniting children with their families.

**HOW DO WE GET STARTED?**

Call 435-3827 for initial information and register for an additional informational meeting.

**WHO ARE OUR CHILDREN?**

Children of all ages come into care, but often our greatest need is finding families who are willing to accept sibling groups, pre-teens, teenagers, medically fragile infants and young children and homes willing to take care of a child when an emergency removal takes place**.** Children enter our care for a variety of reasons-primarily due to a history of abuse and neglect. These children could greatly benefit from a supportive & caring home environment.

**WHAT ARE THE QUALIFICATIONS TO BECOME A FOSTER PARENT?**

You must be 21 years of age, be financially stable with a steady means of income, have at least two bedrooms in your home or rented apartment, complete extensive Criminal history and Child Abuse clearances, and have a way for the agency to contact you.

**WHAT KIND OF HELP DO FOSTER PARENTS RECEIVE?**

Foster parent receive a monthly stipend and children in care have medical coverage through Medicaid. We have a specialized medical clinic for children in care for all their medical needs. The children are eligible for child care if their foster parents are employed. Foster parents are reimbursed for mileage when they are transporting children for medical appointments and family visits. Foster Parents receive supports from the child’s caseworker and the family’s home finder. Ongoing training for foster parents is also available.

**DO FOSTER PARENTS ADOPT?**

Yes, many of our Foster/Adopt families do adopt. Most Foster/Adopt families continue to provide foster care for children in our community even after adopting.

**Looking to Adopt?**

Our Foster/Adoptive program dually certifies you to be both a foster and adoptive parent.

Children who enter care range from Birth to 21 years of age that have been living in an unsafe environment. Our greatest need is for homes that are willing to foster and adopt, as it is rare that children come into care already freed for adoption.

**Who are our Children?**

Like the population at large, our children may be typical, or they may have physical, mental, or emotional difficulties.

We need homes for sibling groups or adoptive homes for older children. Furthermore, we ask for families to provide a nurturing, safe, stable environment while helping to transition the child back to their family. If reunification is not possible, we ask that these homes become a permanent resource for the child or children in their home.

However, if you do not think it would be possible for you to provide a foster home for a child in care you can always look at the state’s registry of children freed for adoption.

**https:www.ocfs.state.ny.us/adopt/**

This site provides both a video gallery of adoptive children and adoption photo listings including the Silverlight adoption album of children in need of a permanent home. There are also many private adoption agencies that handle adoptions.

**PLEASE BRING THE ATTACHED FORMS COMPLETED TO YOUR ORIENTATION MEETING!**

**These forms will allow you to move forward with the process after your orientation if you determine being a foster parent is right for you!**

**If you have not scheduled an informational meeting, please call:**

**315-435-3827**

**Self -Assessment**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**SELF-ASSESSMENT**

**The purpose of this form is for applicant(s) and their families to consider the impact that becoming foster/adoptive parents would have on their lives.**

|  |  |  |
| --- | --- | --- |
| Instructions:  **Applicant(s):** Applicant(s), together with other household members, including applicable children should complete this form. Additional sheets of paper can be used if needed.  **Home finders**: This form must be provided to applicant(s) to complete. Home finders should review the questions below with the applicant(s) and other household members together, at least once prior to application. However, it is recommended that these considerations be assessed throughout the process. The completed form must be maintained in the applicant’s file. | | |
| **NAME OF APPLICANT(S):** | | |
| 1. What influenced you to pursue fostering and/or adopting at this time? | | |
|  | | |
| 1. What does foster care mean to you? | | |
|  | | |
| 2a. What is your understanding of parents with children in foster care? | | |
|  | | |
| 1. What does adoption mean to you? | | |
|  | | |
| 3a. What is your understanding of children in foster care awaiting adoption? | | |
|  | | |
| 1. What do you think are the major differences between fostering and adopting? | | |
|  | | |
| 1. To what extent were your family and other household members, including children, part of the decision to become a foster and/or adoptive family? | | |
|  | | |
| 1. What type of supports do you think a child may need who is separated from their family? | | |
|  | | |
| 6a. Describe how you would provide support? | | |
|  | | |
| 1. How will you work with this agency to help the child in foster care return to their family? | | |
|  | | |
| 7a. How will you work with this agency to help the child transition to adoption if needed? | | |
|  | | |
| 1. To what extent will you support arranging for the child to visit with birth family, siblings, grandparents, etc.? | | |
|  | | |
| 8a. To what extent would you participate with the child in visits with the child’s family? | | |
|  | | |
| 1. What is your understanding of open adoption? | | |
|  | | |
| 1. What are your concerns about adopting from foster care? | | |
|  | | |
| 1. What is your comfort level with frequent visits/communication with agency workers? | | |
|  | | |
| 1. How do you feel about sharing personal information about your life throughout this process? | | |
|  | | |
| 1. What do you think will be the most positive and the most challenging impacts on you and your family for fostering? | | |
|  | | |
| 13a. For adopting? | | |
|  | | |
| 1. How would you support a child in foster care or a child awaiting adoption maintaining connections if not of the same religious, ethnic, racial and/or cultural background as your family? | | |
|  | | |
| 1. How do you foresee changing your schedule to accommodate the needs of a child(ren)? | | |
|  | | |
| 15a. How would your work schedule be affected? | | |
|  | | |
| 1. Would your physical space need to be modified to accommodate a child(ren)? | | |
|  | | |
| 1. What are your thoughts about including the child(ren) in your daily activities, community events, family events, etc.? | | |
|  | | |
| 1. Do you have pets? | | |
| Yes  No | | |
| 18a. If so, what type and how many? | | |
|  | | |
| 18b. How well do they respond to children and/or other strangers in the home? | | |
|  | | |
| 1. How long do you think you will be willing and able to foster? | | |
|  | | |
| 1. Training is required to be certified or approved, and ongoing training is also required. Both applicants need to participate in the initial training, averaging 30 hours over a 10-week period, plus annual trainings. What changes would you need to make to participate in required and ongoing training? | | |
|  | | |
| **What’s Next?** | | |
| Would you like to take the next step in the process?  Yes  No | | |
| If yes, what is your interest at this time?  Foster Care  Adoption  Both | | |
| If yes, do you currently have preferences regarding the number, age ranges, and characteristics of children for whom you want to provide care?  Yes  No  Explain: | | |
| **Initial Assessment of Family Readiness:**  To be completed by the home finder and reviewed with the applicant(s) *(Choose one and explain.)* | Date:       /       / | |
| Early Stages: | | |
| Minimal Supports Needed: | | |
| Acceptable: | | |
| APPLICANT’S SIGNATURE:  **X** | | DATE:        /       / |
| APPLICANT’S SIGNATURE:  **X** | | DATE:        /       / |
| HOME FINDER’S SIGNATURE:  **X** | | DATE:        /       / |
| SUPERVISOR’S SIGNATURE:  **X** | | DATE:        /       / |
| **Reassessment of Family Readiness:** To be completed by the home finder and reviewed with the applicant(s) *(Choose one and explain.)* | Date:       /       / | |
| Early Stages: | | |
| Minimal Supports Needed: | | |
| Acceptable: | | |
| APPLICANT’S SIGNATURE:  **X** | | DATE:        /       / |
| APPLICANT’S SIGNATURE:  **X** | | DATE:        /       / |
| HOME FINDER’S SIGNATURE:  **X** | | DATE:        /       / |
| SUPERVISOR’S SIGNATURE:  **X** | | DATE:        /       / |

**Resource Characteristics**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**RESOURCE CHARACTERISTICS**

Instructions:

**Applicant(s)**: Listed below are characteristics and interests of children who may be in need of a foster care/adoptive placement. Please check those that your family would be willing and able to accommodate.

|  |  |  |
| --- | --- | --- |
| NAME OF APPLICANT(S): | | |
| **CHARACTERISTICS** | **NO** | **YES** |
| Aggression toward others |  |  |
| Aggression toward property |  |  |
| Bedwetting or encopresis |  |  |
| Chronic medical condition |  |  |
| Complex medication regimen |  |  |
| Developmental disability |  |  |
| Dietary restrictions |  |  |
| Frequent appointments |  |  |
| Goal of adoption |  |  |
| Halal |  |  |
| History of fire-setting behavior |  |  |
| History of frequent AWOLs or running away |  |  |
| History of justice involvement |  |  |
| History of sexual abuse |  |  |
| History of sexual exploitation |  |  |
| Intellectual disability |  |  |
| Issues with activities of daily living |  |  |
| Kosher |  |  |
| Lesbian, gay, or bisexual (LGB) |  |  |
| Need for a handicap-accessible resource |  |  |
| Need for a non-smoking resource |  |  |
| Need for a resource with no pets |  |  |
| Pregnant or parenting |  |  |
| Self-injury |  |  |
| Special education needs |  |  |
| Special equipment for medical condition |  |  |
| Substance use **not** requiring treatment |  |  |
| Symptoms of autism |  |  |
| Transgender or gender non-conforming (TGNC) |  |  |
| Verbal aggression |  |  |

|  |  |  |
| --- | --- | --- |
| **INTERESTS** | **NO** | **YES** |
| Arts and Crafts |  |  |
| Cooking/Baking |  |  |
| Movies, Video Games, or Television |  |  |
| Music |  |  |
| Outdoor Activities |  |  |
| Performing Arts |  |  |
| Reading/Creative Writing |  |  |
| Science/Math |  |  |
| Sports |  |  |
| Technology/Engineering |  |  |

|  |  |
| --- | --- |
| APPLICANT’S SIGNATURE:  **X** | DATE:  **/** **/** |
| APPLICANT’S SIGNATURE:  **X** | DATE:  **/       /** |

**Foster/Adoptive Parent**

**Application**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**FOSTER/ADOPTIVE PARENT APPLICATION**

Instructions:

**Applicant(s):** Each applicant must complete a separate application form.The home finder will notify the applicantif supporting documentation is required.

|  |  |  |
| --- | --- | --- |
| **APPLICANT INFORMATION** | | |
| APPLYING FOR:  FOSTER CARE ONLY  FOSTER CARE AND ADOPTION\*  \*Complete *Family Adoption Registry* (OCFS-5183C) | | |
| Are you or have you ever been a certified or approved emergency foster parent?  No  Yes  Date of expiration:  Are you applying for certification or approval for a specific child(ren)?  No  Yes  If yes: | | |
| **NAME OF CHILD** | **DATE OF BIRTH** | **RELATIONSHIP TO APPLICANT** |
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| NAME OF APPLICANT: | | | | | | | | | | | | | | | | | |
| LAST, FIRST, MIDDLE INITIAL: | | | | | | | | | | | | | | | | | |
| DATE OF BIRTH:        /       / | | | | SOCIAL SECURITY NUMBER:      -    - | | | | | | Email Address: | | | | | | | |
| PHONE CONTACT INFORMATION:  **HOME PHONE:** (     )       -        N/A                                     **CELL PHONE:** (     )       -            N/A | | | | | | | | | | | | | | | | | |
| CURRENT ADDRESS: | | | | | | | | | | | | | | | | | |
| CITY: | | | | | | | | | STATE: | | | | | | ZIP CODE: | | |
| How long have you:  Owned        Rented | | | | | SCHOOL DISTRICT: | | | | | | | | | | | | |
| **MARITAL STATUS:** | | Married  Divorced  Single  Widow/Widower  Separated  Couple living together | | | | | | | | | | | | | | | |
| **DEMOGRAPHICS[[1]](#footnote-1)** | | | | | | | | | | | | | | | | | |
| **SEX:**[[2]](#footnote-2)  Female  Male  **WHAT ARE YOUR PRONOUNS?**  She/her/hers  He/him/his  They/them/theirs  OTHER  **GENDER IDENTITY:**[[3]](#footnote-3)  Female  Male  Transgender  Gender non-conforming  Other/Something else  Don’t know  Decline to answer  **SEXUAL ORIENTATION:[[4]](#footnote-4)**  Straight/Heterosexual  Gay or Lesbian  Bisexual   Other/Something else  Don’t know  Decline to answer | | | | | | | | | | | | | | | | | |
| RACE: | | | | | ETHNICITY: | | | | | | RELIGIOUS AFFILIATION: | | | | | | |
| LANGUAGES SPOKEN: | | | | | | | | | | | | | | | | | |
| **NATIVE AMERICAN**?  No  Yes *If yes, Tribal/Nation affiliation*: | | | | | | | | | | | | | | | | | |
| **HOUSEHOLD MEMBER INFORMATION** \*Social Security Number (SSN) is required for individuals 18 years of age or older | | | | | | | | | | | | | | | | | |
|  | **LAST NAME, FIRST NAME** | | | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | | **LAST NAME, FIRST NAME** | | | **LAST NAME, FIRST NAME** |
| **DATE OF BIRTH** |  | | | |  | |  | |  | |  | | |  | | |  |
| **RELATIONSHIP TO APPLICANT** |  | | | |  | |  | |  | |  | | |  | | |  |
| **RELIGION** |  | | | |  | |  | |  | |  | | |  | | |  |
| **SEX** |  | | | |  | |  | |  | |  | | |  | | |  |
| **ETHNICITY** |  | | | |  | |  | |  | |  | | |  | | |  |
| **LANGUAGE** |  | | | |  | |  | |  | |  | | |  | | |  |
| **MARITAL STATUS** |  | | | |  | |  | |  | |  | | |  | | |  |
| **\*SSN** |  | | | |  | |  | |  | |  | | |  | | |  |
| Are any children in your household in foster care and awaiting adoption?  No  Yes *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| Applicable for children surrendered directly to a voluntary authorized agency: Are any children in your household awaiting adoption finalization?  No  Yes  *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| **Other children**  **(under 18) RESIDING outside the household** | | | | | **Date of birth** | | | **Address** | | | | | | | | **Relationship to applicant** | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Adult children RESIDING outside the household** | | | | | **Date of birth** | | | **Address** | | | | | | | | **Relationship to applicant** | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Boarders/Renters** | | | | | | | **Date of birth** | | | | | **Relationship to applicant** | | | | | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Pets/other animals – Type**  **per local ordinance** | | | | | | | | | | | | **Vaccinated?** | | | **Licensed?** | | |
| N/A | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
| **FOSTER/ADOPTIVE PARENTING EXPERIENCE** | | | | | | | | | | | | | | | | | |
| Are you currently an approved adoptive parent?  No  Yes  *If yes, please provide approval dates and the approving agency’s name and contact information.* | | | | | | | | | | | | | | | | | |
| **ApprovAL date:** | | | **ApprovING agency:** | | | | | | | | | **Contact information:** | | | | | |
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| Have you previously applied to be a foster or adoptive parent in this state or another state?  No  Yes  *If yes, please provide agency name and contact information.* | | | | | | | | | | | | | | | | | |
| **agency:** | | | | | | | **Contact information:** | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | |
| Were you accepted, withdrawn, or denied?  Accepted  Withdrawn  Denied *If withdrawn or denied, what was the reason?* | | | | | | | | | | | | | | | | | |
| Have you had a foster parent certification or approval revoked, suspended, surrendered or lapsed? | | | | | | | | | | | | | | | | | |
| N/A  No  Yes  *If yes, what was the reason?* | | | | | | | | | | | | | | | | | |
| **TRANSPORTATION** | | | | | | | | | | | | | | | | | |
| What are your plans for transporting the child in foster care? | | | | | | | | | | | | | | | | | |
| If your answer was “personal vehicle”:  Do you have a:  Valid driver’s license?  No  Yes *If yes, expiration date*:       /       /  Valid car insurance?  No  Yes *If yes, expiration date*:       /       /  Valid registration?  No  Yes *If yes, expiration date*:       /       /  Valid inspection?  No  Yes *If yes, expiration date*:       /       / | | | | | | | | | | | | | | | | | |
| **REFERENCES** | | | | | | | | | | | | | | | | | |
| List three references, other than relatives, who can serve as personal references | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | **Address** | | | | | **Phone/Email address** | | | | | |
|  | | | | | | |  | | | | |  | | | | | |
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| If applicable, list one reference who can verify your work record and qualifications | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | **Address** | | | | | **Phone/Email address** | | | | | |
|  | | | | | | |  | | | | | (     )       -      , | | | | | |
| **EMPLOYMENT INFORMATION** | | | | | | | | | | | | | | | | | |
| Do you provide child care/ day care in your home?  No  Yes  *If yes,*   1. *What are the hours of operation?* 2. *Number of children?* 3. *Describe:* | | | | | | | | | | | | | | | | | |
| Do you operate a Family-Type Home for Adults?  No  Yes  *If yes,*   1. *Describe:* | | | | | | | | | | | | | | | | | |
| Do you operate any other business out of your home?  No  Yes  *If yes,*   1. *What are the hours of operation?* 2. *Do you have a license for any of the businesses in your home?* 3. *Describe:* | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| What are your plans for supervision of a child(ren) when you are not available (i.e., during work hours, after school, summer, etc.): | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **CURRENT EMPLOYMENT INFORMATION** | | | | | | | | | | | | | | | | | |
| CURRENT EMPLOYER: | | | | | | | | | | | | START DATE: | | | | | |
| EMPLOYER ADDRESS: | | | | | | | | | | | | | | | | | |
| CITY: | | | | | | | STATE: | | | | | ZIP CODE: | | | | | |
| POSITION: | | | | | | | SCHEDULE: | | | | | | | | | | |
| EMPLOYER CONTACT NAME: | | | | | | | EMPLOYER CONTACT NUMBER: | | | | | EMPLOYER CONTACT EMAIL: | | | | | |
| **EMPLOYMENT HISTORY** | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week: | | | | | | | | | | | | | | | | | |
| Reason for leaving: | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week: | | | | | | | | | | | | | | | | | |
| Reason for leaving: | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week:  Reason for leaving: | | | | | | | | | | | | | | | | | |
| **EDUCATION HISTORY** | | | | | | | | | | | | | | | | | |
| HIGHEST EDUCATION COMPLETED:  Grade School  High School  TASC (GED)  Associate’s Degree  Bachelor’s Degree  Master’s Degree  Ph. D.  Other: | | | | | | | | | | | | | | | | | |
| **FINANCIAL INFORMATION** | | | | | | | | | | | | | | | | | |
| INCOME FROM EMPLOYMENT: | | | | | | | |  | | | | | | | | | |
| OTHER INCOME AND SOURCE: | | | | | | | | PA  SSI  SSD  Disability  Child Support  Other, specify: | | | | | | | | | |
| TOTAL MONTHLY INCOME: | | | | | | | |  | | | | | | | | | |
| **MONTHLY Expenses:** | | | | | | | | | | | | | | | | | |
| Is your family experiencing any financial stressors (i.e., foreclosure, bankruptcy, etc.)?  No  Yes  *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| Does your family have medical insurance coverage?  No  Yes | | | | | | | | | | | | | | | | | |
| ► rent/mortgage | | | | | | $ | | | | | | | | | | | |
| ► utilities (including phones and cable) | | | | | | $ | | | | | | | | | | | |
| ► car payments | | | | | | $ | | | | | | | | | | | |
| ► car insurance | | | | | | $ | | | | | | | | | | | |
| ► other insurance | | | | | | $ | | | | | | | | | | | |
| ► loans/debts, credit cards | | | | | | $ | | | | | | | | | | | |
| ► food, clothing, etc. | | | | | | $ | | | | | | | | | | | |
| ► entertainment | | | | | | $ | | | | | | | | | | | |
| **Total monthly expenses** | | | | | | $ | | | | | | | | | | | |
| APPLICANT’S SIGNATURE:  **X** | | | | | | | | | | | | | DATE:  **/       /** | | | | |

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| **SWORN STATEMENT** – One per applicant | | | | | | |
| Please answer the questions below in full. | | | | | | |
| LAST NAME: | FIRST NAME: | | | | MIDDLE NAME: | |
| MAIDEN NAME OR ANY OTHER ALIAS: | | | | | | |
| CURRENT MAILING STREET ADDRESS: | | CITY: | STATE: | | | ZIP CODE: |
| 1. Have you ever been convicted of a crime within New York State or any other jurisdiction or state? | | | No  Yes | | | |
| *If yes, provide an explanation for each crime for which you were convicted of including the type of crime, the location, the date and circumstances*: | | | | | | |
| 1. Has any person age 18 or older currently residing in the home ever been convicted of a crime within New York State or any other jurisdiction or state? | | | No  Yes | | | |
| *If yes, provide an explanation for each crime for which the person(s) was/were convicted of, including the type of crime, the location, the date and circumstances*: | | | | | | |
| **To the best of my knowledge, I hereby affirm that the information provided above is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation may result in disqualification as an applicant for deliberately presenting false or misleading information.** | | | | | | |
| APPLICANT’S SIGNATURE:  **X** | | | | DATE:        /       / | | |

**Application to Adopt**

| NEW YORK STATE  OFFICE OF CHILDREN AND FAMILY SERVICES  **Family Adoption Registry Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| This registry is a tool for families who are interested in adopting photolisted children, and it is available to adoption staff to facilitate matching children to prospective families. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME OF APPLICANT(S): | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE:** Select **ALL** acceptable characteristics. You may choose more than one entry in each area. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sex:** Male  Female  Other | | | **Age:**      *Under 2*       *2-5*       *6-7*       *8-9*       *10-13*       *Over 13* | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Primary Language Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Secondary Language Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Religion Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ETHNICITY CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | **LANGUAGE CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | |
| **AA** | Black or African American | | | **ASI** | | | | Indian | | | | | | | **AI** | | Nat Am Lan | | | | | | **KM** | | | Cambodian | | |
| **AAC** | Caribbean | | | **ASJ** | | | | Japanese | | | | | | | **AL** | | Albanian | | | | | | **KR** | | | Korean | | |
| **AAH** | Haitian | | | **ASK** | | | | Korean | | | | | | | **AR** | | Arabic | | | | | | **LA** | | | Laotian | | |
| **AAN** | Native African | | | **ASX** | | | | Other - Asian | | | | | | | **BN** | | Bengali | | | | | | **MU** | | | Multiple | | |
| **AAX** | Other - Black or African American | | | **HP** | | | | Hispanic | | | | | | | **BS** | | Bosnian | | | | | | **NI** | | | Nigeria Igbo | | |
| **AL** | Alaskan Native | | | **ML** | | | | Multiple | | | | | | | **CC** | | Cantonese | | | | | | **PJ** | | | Punjabi | | |
| **AM** | Native American | | | **PI** | | | | Native Hawaiian/Pacific Islander | | | | | | | **CF** | | Fujianese | | | | | | **PL** | | | Polish | | |
| **AS** | Asian | | | **WH** | | | | White | | | | | | | **CH** | | Chinese Other | | | | | | **PR** | | | Portuguese | | |
| **ASC** | Chinese | | | **XNR** | | | | Not Reported | | | | | | | **CM** | | Mandarin | | | | | | **PT** | | | Patois | | |
| **RELIGION CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | | **CR** | | Haitian Creole | | | | | | **RO** | | | Romanian | | |
| **CZ** | | Czech | | | | | | **RS** | | | Russian | | |
| **AT** | African Religion | | | **IS** | | | | Muslim/Islamic | | | | | | | **EN** | | English | | | | | | **SC** | | | Serbo-Croatian | | |
| **BA** | Baptist | | | **JW** | | | | Jehovah's Witness | | | | | | | **ET** | | Ethiopian | | | | | | **SI** | | | American Sign | | |
| **BP** | Other Protestant | | | **LU** | | | | Lutheran | | | | | | | **FA** | | Farsi | | | | | | **SL** | | | Braille | | |
| **BU** | Buddhist | | | **ME** | | | | Methodist/Wesleyan | | | | | | | **FL** | | Fulani | | | | | | **SP** | | | Spanish | | |
| **CJ** | Jewish | | | **MO** | | | | Mormon | | | | | | | **FO** | | Filipino | | | | | | **TL** | | | Tagalog | | |
| **CS** | Christian Science | | | **NA** | | | | Native American | | | | | | | **FR** | | French | | | | | | **UK** | | | Unknown | | |
| **CT** | Chinese Traditional | | | **OC** | | | | Other Christian | | | | | | | **GK** | | Greek | | | | | | **UR** | | | Urdu | | |
| **DE** | Other Eastern | | | **PE** | | | | Pentecostal | | | | | | | **GR** | | German | | | | | | **VT** | | | Vietnamese | | |
| **EN** | None/Secular | | | **PR** | | | | Presbyterian | | | | | | | **GU** | | Gujarati | | | | | | **YI** | | | Yiddish | | |
| **EP** | Episcopal/Anglican | | | **RC** | | | | Catholic | | | | | | | **HI** | | Hindi | | | | | | **XX** | | | Other | | |
| **FP** | No Preference | | | **RO** | | | | Russian Orthodox | | | | | | | **HW** | | Hebrew | | | | | |  | | |  | | |
| **GO** | Greek Orthodox | | | **UN** | | | | Unknown | | | | | | | **IT** | | Italian | | | | | |  | | |  | | |
| **HI** | Hindu | | | **UU** | | | | Unitarian/Universal | | | | | | | **JP** | | Japanese | | | | | |  | | |  | | |
|  |  | | | **XX** | | | | Other | | | | | | | **KH** | | Khmer | | | | | |  | | |  | | |
| **If you will consider a child with special needs and individual needs check ALL appropriate choices in the boxes below:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CATEGORIES OF CHILD NEEDS** | | | | | | | | | | | **MILD** | | | | | | | | **MODERATE** | | | | | | **SEVERE** | | | |
| Medical/Physical Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Educational/Learning Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Mental Health Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Developmental Delay Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Would you be willing to accept a “legally at-risk” child?  No  Yes | | | | | | | | | | | | Would you be interested in adopting a sibling group?  No  Yes | | | | | | | | | | | | | | | | |

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| APPLICANT’S SIGNATURE:  **X** | DATE:  **/       /** |
| APPLICANT’S SIGNATURE:  **X** | DATE:  **/       /** |

**CATEGORIES OF CHILD NEEDS**

**Medical/Physical Needs** - This category includes children with specific medical/physical needs who may require an additional level of care beyond that normally given at the child’s age level. This category includes children who may display some of the following medical problems that range from acute to chronic and/or terminal illness: children who experience respiratory problems ranging from asthma to reactive airway disease; children who have skin conditions that range from eczema to those that require surgical/medical intervention; children with physical disabilities that impair the use of vision, hearing and mobility; and children with neurological problems that range from seizure disorders to different levels of cerebral palsy. This section will include infants that require additional medical intervention as well as some children who have gastrointestinal medical needs, and children who experience a wide range of allergy conditions. Additionally, children with conditions such as Down syndrome, fetal alcohol syndrome, Tourette and sickle cell disease will be included in this section.

**Educational/Learning Needs** - This category includes children with educational/learning needs ranging from educational support to diagnosed learning disabilities. Examples will include visual/receptive/auditory processing difficulties, dyslexia, and educational delays. In addition, children may require special educational intervention.

**Mental Health Needs** - This category includes children with mental/emotional disorders ranging from experiencing acting-out behavioral and emotional problems to having been adjudicated Persons in Need of Supervision (PINS) and Juvenile Delinquents. Further examples of mental health needs include children exhibiting some of the following behaviors: low-frustration tolerance, early sexual activity, sexually acting-out behavior, enuresis, encopresis, and cruelty to animals. Also included are children who exhibit these issues: resistance to adult authority, have difficulty with their peers, runaway behavior, school absence and or discipline issues, diagnosed attention problems including Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, substance abuse sleep disorders, and theft and gang activity. Children who are physically aggressive, violent, and destructive will be noted here.

**Developmental Delay Needs** - This category includes children whose developmental needs range from receptive/ expressive language, fine/gross motor skills, social adaptations, and self-help skills to those needing intensive assistance in self-help skills and assistance towards achieving independent living. Also, included in this section are children who have temporary developmental delays or more permanent deficits.

**EXPLANATION OF MILD, MODERATE, AND SEVERE LEVELS**

**MILD**

**Medical/Physical Needs** – Child has a condition(s) that requires non-acute medical attention such as: visual or hearing impairments, allergies, asthma, controllable epilepsy or follow-up conditions, which have been surgically corrected such as open-heart surgery.

**Educational/Learning Needs** – Child is slightly behind in one or more subjects but attends regular school classes. Child may have some minor learning disabilities.

**Mental Health Needs** – Child has a diagnosed condition that may mildly impair their ability to function such as an adjustment or attachment disorder. Child is generally emotionally stable, but may be facing a situation (disruption, new foster home) that has created a temporary emotional stress and may need to be addressed. Child has or has had a problem controlling their behavior, usually associated with a specific incident such as a disruption.

**Developmental Needs** – Child has a mild delay in development and may be receiving speech, occupational, or physical therapy.

**MODERATE**

**Medical/Physical Needs** – Child that has a moderate level of cerebral palsy, cleft defects that have not yet been surgically treated, sickle cell disease if severe complications are not present, partial impairment of normal movement, diabetes, heart defects that can be repaired, spina bifida without the most severe complications.

**Educational/Learning Needs** – Child is two to three years behind in subjects and receiving resource room help or other special tutoring aside from being in the regular classroom.

**Mental Health Needs** - Children with one of the described conditions requiring ongoing intervention services and a higher level of supervision and or treatment. Child is experiencing emotionally related problems that may interfere with child’s school performance or interaction with others. Child has a history of acting out, causing problems at school and in interpersonal relationships.

**Developmental Needs** – Child needs assistance with skills of daily living. Child is receiving early intervention services for significant lags in speech, fine/gross motor skills.

**SEVERE:**

**Medical/Physical Needs** - Children with spina bifida with severe complications, muscular dystrophy, cerebral palsy with severe intellectual disability and/or paralysis, total paralysis, cystic fibrosis, blindness, total deafness, and terminal illnesses.

**Educational/Learning Needs** - Children diagnosed as learning disabled or mentally disabled that are in special classroom settings.

**Mental Health Needs** - Children who are schizophrenic, autistic, and/or who act out destructively such as a fire-setter or a serious suicide risk. Children who are seriously emotionally disturbed, are in residential treatment, are receiving intensive therapy, or are in emotionally handicapped classroom settings. Children who exhibit severe acting out and/or violent behavior. Children on medication to control their behavior.

**Developmental Needs** - Children with severe mental disability. Children receiving intensive therapy to obtain skills of daily living, children needing extensive supervision for daily functioning.

**Accept Child Who Is “Legally at Risk”** - Indicate with an “X” if applicant is willing to accept a child who is legally at risk. Detailed below, are two definitions associated with “Legally at Risk.”

• The child’s birth parents have not terminated their parental rights and/or surrendered the child. Therefore, the child may not become available for adoption.

**Note:** This definition is appropriate for the recruitment and placement of children.

• A child is freed for adoption, and there are potential legal impediments to the completion of the adoption including, but not limited to:

a) there is a pending appeal of the termination of parental rights;

b) there is a putative father who is claiming to be a person whose consent to the adoption is required;

c) there is a conditional surrender where the surrender limits or restricts who the adoptive parent can be; and

d) the child’s immigration status.

**Note:** This definition is appropriate for matching and searching photolisted children with families registered in the Family Adoption Registry.

**Foster/Adoptive Parent**

**Application**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**FOSTER/ADOPTIVE PARENT APPLICATION**

Instructions:

**Applicant(s):** Each applicant must complete a separate application form.The home finder will notify the applicantif supporting documentation is required.

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| **APPLICANT INFORMATION** | | |
| APPLYING FOR:  FOSTER CARE ONLY  FOSTER CARE AND ADOPTION\*  \*Complete *Family Adoption Registry* (OCFS-5183C) | | |
| Are you or have you ever been a certified or approved emergency foster parent?  No  Yes  Date of expiration:  Are you applying for certification or approval for a specific child(ren)?  No  Yes  If yes: | | |
| **NAME OF CHILD** | **DATE OF BIRTH** | **RELATIONSHIP TO APPLICANT** |
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| NAME OF APPLICANT: | | | | | | | | | | | | | | | | | |
| LAST, FIRST, MIDDLE INITIAL: | | | | | | | | | | | | | | | | | |
| DATE OF BIRTH:        /       / | | | | SOCIAL SECURITY NUMBER:      -    - | | | | | | Email Address: | | | | | | | |
| PHONE CONTACT INFORMATION:  **HOME PHONE:** (     )       -        N/A                                     **CELL PHONE:** (     )       -            N/A | | | | | | | | | | | | | | | | | |
| CURRENT ADDRESS: | | | | | | | | | | | | | | | | | |
| CITY: | | | | | | | | | STATE: | | | | | | ZIP CODE: | | |
| How long have you:  Owned        Rented | | | | | SCHOOL DISTRICT: | | | | | | | | | | | | |
| **MARITAL STATUS:** | | Married  Divorced  Single  Widow/Widower  Separated  Couple living together | | | | | | | | | | | | | | | |
| **DEMOGRAPHICS[[5]](#footnote-5)** | | | | | | | | | | | | | | | | | |
| **SEX:**[[6]](#footnote-6)  Female  Male  **WHAT ARE YOUR PRONOUNS?**  She/her/hers  He/him/his  They/them/theirs  OTHER  **GENDER IDENTITY:**[[7]](#footnote-7)  Female  Male  Transgender  Gender non-conforming  Other/Something else  Don’t know  Decline to answer  **SEXUAL ORIENTATION:[[8]](#footnote-8)**  Straight/Heterosexual  Gay or Lesbian  Bisexual  Other/Something else  Don’t know  Decline to answer | | | | | | | | | | | | | | | | | |
| RACE: | | | | | ETHNICITY: | | | | | | RELIGIOUS AFFILIATION: | | | | | | |
| LANGUAGES SPOKEN: | | | | | | | | | | | | | | | | | |
| **NATIVE AMERICAN**?  No  Yes *If yes, Tribal/Nation affiliation*: | | | | | | | | | | | | | | | | | |
| **HOUSEHOLD MEMBER INFORMATION** \*Social Security Number (SSN) is required for individuals 18 years of age or older | | | | | | | | | | | | | | | | | |
|  | **LAST NAME, FIRST NAME** | | | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | **LAST NAME, FIRST NAME** | | | **LAST NAME, FIRST NAME** | | | **LAST NAME, FIRST NAME** |
| **DATE OF BIRTH** |  | | | |  | |  | |  | |  | | |  | | |  |
| **RELATIONSHIP TO APPLICANT** |  | | | |  | |  | |  | |  | | |  | | |  |
| **RELIGION** |  | | | |  | |  | |  | |  | | |  | | |  |
| **SEX** |  | | | |  | |  | |  | |  | | |  | | |  |
| **ETHNICITY** |  | | | |  | |  | |  | |  | | |  | | |  |
| **LANGUAGE** |  | | | |  | |  | |  | |  | | |  | | |  |
| **MARITAL STATUS** |  | | | |  | |  | |  | |  | | |  | | |  |
| **\*SSN** |  | | | |  | |  | |  | |  | | |  | | |  |
| Are any children in your household in foster care and awaiting adoption?  No  Yes *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| Applicable for children surrendered directly to a voluntary authorized agency: Are any children in your household awaiting adoption finalization?  No  Yes  *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| **Other children**  **(under 18) RESIDING outside the household** | | | | | **Date of birth** | | | **Address** | | | | | | | | **Relationship to applicant** | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Adult children RESIDING outside the household** | | | | | **Date of birth** | | | **Address** | | | | | | | | **Relationship to applicant** | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Boarders/Renters** | | | | | | | **Date of birth** | | | | | **Relationship to applicant** | | | | | |
| N/A | | | | | | | | | | | | | | | | | |
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| **Pets/other animals – Type**  **per local ordinance** | | | | | | | | | | | | **Vaccinated?** | | | **Licensed?** | | |
| N/A | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
|  | | | | | | | | | | | | No  Yes | | | No  Yes | | |
| **FOSTER/ADOPTIVE PARENTING EXPERIENCE** | | | | | | | | | | | | | | | | | |
| Are you currently an approved adoptive parent?  No  Yes  *If yes, please provide approval dates and the approving agency’s name and contact information.* | | | | | | | | | | | | | | | | | |
| **ApprovAL date:** | | | **ApprovING agency:** | | | | | | | | | **Contact information:** | | | | | |
| /       / | | |  | | | | | | | | |  | | | | | |
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| Have you previously applied to be a foster or adoptive parent in this state or another state?  No  Yes  *If yes, please provide agency name and contact information.* | | | | | | | | | | | | | | | | | |
| **agency:** | | | | | | | **Contact information:** | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | |
| Were you accepted, withdrawn, or denied?  Accepted  Withdrawn  Denied *If withdrawn or denied, what was the reason?* | | | | | | | | | | | | | | | | | |
| Have you had a foster parent certification or approval revoked, suspended, surrendered or lapsed? | | | | | | | | | | | | | | | | | |
| N/A  No  Yes  *If yes, what was the reason?* | | | | | | | | | | | | | | | | | |
| **TRANSPORTATION** | | | | | | | | | | | | | | | | | |
| What are your plans for transporting the child in foster care? | | | | | | | | | | | | | | | | | |
| If your answer was “personal vehicle”:  Do you have a:  Valid driver’s license?  No  Yes *If yes, expiration date*:       /       /  Valid car insurance?  No  Yes *If yes, expiration date*:       /       /  Valid registration?  No  Yes *If yes, expiration date*:       /       /  Valid inspection?  No  Yes *If yes, expiration date*:       /       / | | | | | | | | | | | | | | | | | |
| **REFERENCES** | | | | | | | | | | | | | | | | | |
| List three references, other than relatives, who can serve as personal references | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | **Address** | | | | | **Phone/Email address** | | | | | |
|  | | | | | | |  | | | | |  | | | | | |
|  | | | | | | |  | | | | |  | | | | | |
|  | | | | | | |  | | | | |  | | | | | |
| If applicable, list one reference who can verify your work record and qualifications | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | **Address** | | | | | **Phone/Email address** | | | | | |
|  | | | | | | |  | | | | | (     )       -      , | | | | | |
| **EMPLOYMENT INFORMATION** | | | | | | | | | | | | | | | | | |
| Do you provide child care/ day care in your home?  No  Yes  *If yes,*   1. *What are the hours of operation?* 2. *Number of children?* 3. *Describe:* | | | | | | | | | | | | | | | | | |
| Do you operate a Family-Type Home for Adults?  No  Yes  *If yes,*   1. *Describe:* | | | | | | | | | | | | | | | | | |
| Do you operate any other business out of your home?  No  Yes  *If yes,*   1. *What are the hours of operation?* 2. *Do you have a license for any of the businesses in your home?* 3. *Describe:* | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| What are your plans for supervision of a child(ren) when you are not available (i.e., during work hours, after school, summer, etc.): | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **CURRENT EMPLOYMENT INFORMATION** | | | | | | | | | | | | | | | | | |
| CURRENT EMPLOYER: | | | | | | | | | | | | START DATE: | | | | | |
| EMPLOYER ADDRESS: | | | | | | | | | | | | | | | | | |
| CITY: | | | | | | | STATE: | | | | | ZIP CODE: | | | | | |
| POSITION: | | | | | | | SCHEDULE: | | | | | | | | | | |
| EMPLOYER CONTACT NAME: | | | | | | | EMPLOYER CONTACT NUMBER: | | | | | EMPLOYER CONTACT EMAIL: | | | | | |
| **EMPLOYMENT HISTORY** | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week: | | | | | | | | | | | | | | | | | |
| Reason for leaving: | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week: | | | | | | | | | | | | | | | | | |
| Reason for leaving: | | | | | | | | | | | | | | | | | |
| Employer:  Dates of employment:       /       /       To       /       /  Position:  Hours worked per week:  Reason for leaving: | | | | | | | | | | | | | | | | | |
| **EDUCATION HISTORY** | | | | | | | | | | | | | | | | | |
| HIGHEST EDUCATION COMPLETED:  Grade School  High School  TASC (GED)  Associate’s Degree  Bachelor’s Degree  Master’s Degree  Ph. D.  Other: | | | | | | | | | | | | | | | | | |
| **FINANCIAL INFORMATION** | | | | | | | | | | | | | | | | | |
| INCOME FROM EMPLOYMENT: | | | | | | | |  | | | | | | | | | |
| OTHER INCOME AND SOURCE: | | | | | | | | PA  SSI  SSD  Disability  Child Support  Other, specify: | | | | | | | | | |
| TOTAL MONTHLY INCOME: | | | | | | | |  | | | | | | | | | |
| **MONTHLY Expenses:** | | | | | | | | | | | | | | | | | |
| Is your family experiencing any financial stressors (i.e., foreclosure, bankruptcy, etc.)?  No  Yes  *If yes, please explain*: | | | | | | | | | | | | | | | | | |
| Does your family have medical insurance coverage?  No  Yes | | | | | | | | | | | | | | | | | |
| ► rent/mortgage | | | | | | $ | | | | | | | | | | | |
| ► utilities (including phones and cable) | | | | | | $ | | | | | | | | | | | |
| ► car payments | | | | | | $ | | | | | | | | | | | |
| ► car insurance | | | | | | $ | | | | | | | | | | | |
| ► other insurance | | | | | | $ | | | | | | | | | | | |
| ► loans/debts, credit cards | | | | | | $ | | | | | | | | | | | |
| ► food, clothing, etc. | | | | | | $ | | | | | | | | | | | |
| ► entertainment | | | | | | $ | | | | | | | | | | | |
| **Total monthly expenses** | | | | | | $ | | | | | | | | | | | |
| APPLICANT’S SIGNATURE:  **X** | | | | | | | | | | | | | DATE:  **/       /** | | | | |

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| **SWORN STATEMENT** – One per applicant | | | | | | |
| Please answer the questions below in full. | | | | | | |
| LAST NAME: | FIRST NAME: | | | | MIDDLE NAME: | |
| MAIDEN NAME OR ANY OTHER ALIAS: | | | | | | |
| CURRENT MAILING STREET ADDRESS: | | CITY: | STATE: | | | ZIP CODE: |
| 1. Have you ever been convicted of a crime within New York State or any other jurisdiction or state? | | | No  Yes | | | |
| *If yes, provide an explanation for each crime for which you were convicted of including the type of crime, the location, the date and circumstances*: | | | | | | |
| 1. Has any person age 18 or older currently residing in the home ever been convicted of a crime within New York State or any other jurisdiction or state? | | | No  Yes | | | |
| *If yes, provide an explanation for each crime for which the person(s) was/were convicted of, including the type of crime, the location, the date and circumstances*: | | | | | | |
| **To the best of my knowledge, I hereby affirm that the information provided above is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation may result in disqualification as an applicant for deliberately presenting false or misleading information.** | | | | | | |
| APPLICANT’S SIGNATURE:  **X** | | | | DATE:        /       / | | |

**Application to Adopt**

| NEW YORK STATE  OFFICE OF CHILDREN AND FAMILY SERVICES  **Family Adoption Registry Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| This registry is a tool for families who are interested in adopting photolisted children, and it is available to adoption staff to facilitate matching children to prospective families. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME OF APPLICANT(S): | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE:** Select **ALL** acceptable characteristics. You may choose more than one entry in each area. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sex:** Male  Female  Other | | | **Age:**      *Under 2*       *2-5*       *6-7*       *8-9*       *10-13*       *Over 13* | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Primary Language Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Secondary Language Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
| **Religion Code:** | |  | | |  | |  | |  |  | |  |  | | |  | |  | |  |  |  | |  | | |  |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ETHNICITY CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | **LANGUAGE CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | |
| **AA** | Black or African American | | | **ASI** | | | | Indian | | | | | | | **AI** | | Nat Am Lan | | | | | | **KM** | | | Cambodian | | |
| **AAC** | Caribbean | | | **ASJ** | | | | Japanese | | | | | | | **AL** | | Albanian | | | | | | **KR** | | | Korean | | |
| **AAH** | Haitian | | | **ASK** | | | | Korean | | | | | | | **AR** | | Arabic | | | | | | **LA** | | | Laotian | | |
| **AAN** | Native African | | | **ASX** | | | | Other - Asian | | | | | | | **BN** | | Bengali | | | | | | **MU** | | | Multiple | | |
| **AAX** | Other - Black or African American | | | **HP** | | | | Hispanic | | | | | | | **BS** | | Bosnian | | | | | | **NI** | | | Nigeria Igbo | | |
| **AL** | Alaskan Native | | | **ML** | | | | Multiple | | | | | | | **CC** | | Cantonese | | | | | | **PJ** | | | Punjabi | | |
| **AM** | Native American | | | **PI** | | | | Native Hawaiian/Pacific Islander | | | | | | | **CF** | | Fujianese | | | | | | **PL** | | | Polish | | |
| **AS** | Asian | | | **WH** | | | | White | | | | | | | **CH** | | Chinese Other | | | | | | **PR** | | | Portuguese | | |
| **ASC** | Chinese | | | **XNR** | | | | Not Reported | | | | | | | **CM** | | Mandarin | | | | | | **PT** | | | Patois | | |
| **RELIGION CODE**  (FOR CHILD AND PARENTS) | | | | | | | | | | | | | | | **CR** | | Haitian Creole | | | | | | **RO** | | | Romanian | | |
| **CZ** | | Czech | | | | | | **RS** | | | Russian | | |
| **AT** | African Religion | | | **IS** | | | | Muslim/Islamic | | | | | | | **EN** | | English | | | | | | **SC** | | | Serbo-Croatian | | |
| **BA** | Baptist | | | **JW** | | | | Jehovah's Witness | | | | | | | **ET** | | Ethiopian | | | | | | **SI** | | | American Sign | | |
| **BP** | Other Protestant | | | **LU** | | | | Lutheran | | | | | | | **FA** | | Farsi | | | | | | **SL** | | | Braille | | |
| **BU** | Buddhist | | | **ME** | | | | Methodist/Wesleyan | | | | | | | **FL** | | Fulani | | | | | | **SP** | | | Spanish | | |
| **CJ** | Jewish | | | **MO** | | | | Mormon | | | | | | | **FO** | | Filipino | | | | | | **TL** | | | Tagalog | | |
| **CS** | Christian Science | | | **NA** | | | | Native American | | | | | | | **FR** | | French | | | | | | **UK** | | | Unknown | | |
| **CT** | Chinese Traditional | | | **OC** | | | | Other Christian | | | | | | | **GK** | | Greek | | | | | | **UR** | | | Urdu | | |
| **DE** | Other Eastern | | | **PE** | | | | Pentecostal | | | | | | | **GR** | | German | | | | | | **VT** | | | Vietnamese | | |
| **EN** | None/Secular | | | **PR** | | | | Presbyterian | | | | | | | **GU** | | Gujarati | | | | | | **YI** | | | Yiddish | | |
| **EP** | Episcopal/Anglican | | | **RC** | | | | Catholic | | | | | | | **HI** | | Hindi | | | | | | **XX** | | | Other | | |
| **FP** | No Preference | | | **RO** | | | | Russian Orthodox | | | | | | | **HW** | | Hebrew | | | | | |  | | |  | | |
| **GO** | Greek Orthodox | | | **UN** | | | | Unknown | | | | | | | **IT** | | Italian | | | | | |  | | |  | | |
| **HI** | Hindu | | | **UU** | | | | Unitarian/Universal | | | | | | | **JP** | | Japanese | | | | | |  | | |  | | |
|  |  | | | **XX** | | | | Other | | | | | | | **KH** | | Khmer | | | | | |  | | |  | | |
| **If you will consider a child with special needs and individual needs check ALL appropriate choices in the boxes below:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CATEGORIES OF CHILD NEEDS** | | | | | | | | | | | **MILD** | | | | | | | | **MODERATE** | | | | | | **SEVERE** | | | |
| Medical/Physical Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Educational/Learning Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Mental Health Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Developmental Delay Needs | | | | | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| Would you be willing to accept a “legally at-risk” child?  No  Yes | | | | | | | | | | | | Would you be interested in adopting a sibling group?  No  Yes | | | | | | | | | | | | | | | | |

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| --- | --- |
| APPLICANT’S SIGNATURE:  **X** | DATE:  **/       /** |
| APPLICANT’S SIGNATURE:  **X** | DATE:  **/       /** |

**CATEGORIES OF CHILD NEEDS**

**Medical/Physical Needs** - This category includes children with specific medical/physical needs who may require an additional level of care beyond that normally given at the child’s age level. This category includes children who may display some of the following medical problems that range from acute to chronic and/or terminal illness: children who experience respiratory problems ranging from asthma to reactive airway disease; children who have skin conditions that range from eczema to those that require surgical/medical intervention; children with physical disabilities that impair the use of vision, hearing and mobility; and children with neurological problems that range from seizure disorders to different levels of cerebral palsy. This section will include infants that require additional medical intervention as well as some children who have gastrointestinal medical needs, and children who experience a wide range of allergy conditions. Additionally, children with conditions such as Down syndrome, fetal alcohol syndrome, Tourette and sickle cell disease will be included in this section.

**Educational/Learning Needs** - This category includes children with educational/learning needs ranging from educational support to diagnosed learning disabilities. Examples will include visual/receptive/auditory processing difficulties, dyslexia, and educational delays. In addition, children may require special educational intervention.

**Mental Health Needs** - This category includes children with mental/emotional disorders ranging from experiencing acting-out behavioral and emotional problems to having been adjudicated Persons in Need of Supervision (PINS) and Juvenile Delinquents. Further examples of mental health needs include children exhibiting some of the following behaviors: low-frustration tolerance, early sexual activity, sexually acting-out behavior, enuresis, encopresis, and cruelty to animals. Also included are children who exhibit these issues: resistance to adult authority, have difficulty with their peers, runaway behavior, school absence and or discipline issues, diagnosed attention problems including Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder, substance abuse sleep disorders, and theft and gang activity. Children who are physically aggressive, violent, and destructive will be noted here.

**Developmental Delay Needs** - This category includes children whose developmental needs range from receptive/ expressive language, fine/gross motor skills, social adaptations, and self-help skills to those needing intensive assistance in self-help skills and assistance towards achieving independent living. Also, included in this section are children who have temporary developmental delays or more permanent deficits.

**EXPLANATION OF MILD, MODERATE, AND SEVERE LEVELS**

**MILD**

**Medical/Physical Needs** – Child has a condition(s) that requires non-acute medical attention such as: visual or hearing impairments, allergies, asthma, controllable epilepsy or follow-up conditions, which have been surgically corrected such as open-heart surgery.

**Educational/Learning Needs** – Child is slightly behind in one or more subjects but attends regular school classes. Child may have some minor learning disabilities.

**Mental Health Needs** – Child has a diagnosed condition that may mildly impair their ability to function such as an adjustment or attachment disorder. Child is generally emotionally stable, but may be facing a situation (disruption, new foster home) that has created a temporary emotional stress and may need to be addressed. Child has or has had a problem controlling their behavior, usually associated with a specific incident such as a disruption.

**Developmental Needs** – Child has a mild delay in development and may be receiving speech, occupational, or physical therapy.

**MODERATE**

**Medical/Physical Needs** – Child that has a moderate level of cerebral palsy, cleft defects that have not yet been surgically treated, sickle cell disease if severe complications are not present, partial impairment of normal movement, diabetes, heart defects that can be repaired, spina bifida without the most severe complications.

**Educational/Learning Needs** – Child is two to three years behind in subjects and receiving resource room help or other special tutoring aside from being in the regular classroom.

**Mental Health Needs** - Children with one of the described conditions requiring ongoing intervention services and a higher level of supervision and or treatment. Child is experiencing emotionally related problems that may interfere with child’s school performance or interaction with others. Child has a history of acting out, causing problems at school and in interpersonal relationships.

**Developmental Needs** – Child needs assistance with skills of daily living. Child is receiving early intervention services for significant lags in speech, fine/gross motor skills.

**SEVERE:**

**Medical/Physical Needs** - Children with spina bifida with severe complications, muscular dystrophy, cerebral palsy with severe intellectual disability and/or paralysis, total paralysis, cystic fibrosis, blindness, total deafness, and terminal illnesses.

**Educational/Learning Needs** - Children diagnosed as learning disabled or mentally disabled that are in special classroom settings.

**Mental Health Needs** - Children who are schizophrenic, autistic, and/or who act out destructively such as a fire-setter or a serious suicide risk. Children who are seriously emotionally disturbed, are in residential treatment, are receiving intensive therapy, or are in emotionally handicapped classroom settings. Children who exhibit severe acting out and/or violent behavior. Children on medication to control their behavior.

**Developmental Needs** - Children with severe mental disability. Children receiving intensive therapy to obtain skills of daily living, children needing extensive supervision for daily functioning.

**Accept Child Who Is “Legally at Risk”** - Indicate with an “X” if applicant is willing to accept a child who is legally at risk. Detailed below, are two definitions associated with “Legally at Risk.”

• The child’s birth parents have not terminated their parental rights and/or surrendered the child. Therefore, the child may not become available for adoption.

**Note:** This definition is appropriate for the recruitment and placement of children.

• A child is freed for adoption, and there are potential legal impediments to the completion of the adoption including, but not limited to:

a) there is a pending appeal of the termination of parental rights;

b) there is a putative father who is claiming to be a person whose consent to the adoption is required;

c) there is a conditional surrender where the surrender limits or restricts who the adoptive parent can be; and

d) the child’s immigration status.

**Note:** This definition is appropriate for matching and searching photolisted children with families registered in the Family Adoption Registry.

**PLEASE RETAIN THE ATTACHED FORMS.**

**THEY WILL BE REQUIRED IF YOU CHOOSE TO MOVE FORWARD WITH YOUR APPLICATION PROCESS.**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**FOSTER/ADOPTIVE APPLICANT MEDICAL REPORT (PART ONE)**

Instructions:

**Applicant:** There are three sections to this form. **Section 1** is to be completed by the applicant. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for the applicant.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant.Provide one form per applicant.

|  |  |  |
| --- | --- | --- |
| **PART ONE - Section 1: APPLICANT’S INFORMATION** | | |
| NAME OF APPLICANT: | | |
| Last, First, Middle initial: | DATE OF BIRTH:       /       / | Telephone Number:  (     )       - |
| Address of applicant: | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | |
| APPLICANT’S SIGNATURE:  **X** | | |
| The above-named applicant has applied to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for certification or approval is submitted to the certifying or approving agency. | | |

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| **SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME: |
| AGENCY’S ADDRESS: |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER): |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each applicant. | | | | | |
| **Please respond to each of the following to the best of your knowledge:** | | | | | |
| Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment? | | | | | No  Yes |
| Is this individual currently taking medications? | | | | | No  Yes |
| Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? | | | | | No  Yes |
| Please provide an explanation for any “Yes” response. | | | | | |
| **GENERAL HEALTH REVIEW OF APPLICANT** | | | | | |
| Physical Exam Date:        /       / | Height:        : | Weight:        LBS | Blood Pressure:       / | | |
| Vision: | | Hearing: | | | |
| Cardiovascular: | | Pulmonary: | | | |
| GastroIntestinal: | | Endocrine: | | | |
| Nervous System: | | Muscular/Skeletal: | | | |
| Skin: | | | | | |
| Results of tuberculin test and/or chest X-ray (must be current) | | | | | |
| Date Mantoux (tuberculin) test given:        /       / | | Results of Mantoux test: | | | |
| If chest X-ray or additional tests are required, provide test, date, and results below: | | | | | |
| Does the individual have any communicable disease, infection, illness, or any physical condition that might affect the proper care of child(ren)?  No  Yes  Explain: | | | | | |
| **FINDINGS** | | | | | |
| On the basis of my findings, as indicated above, and my knowledge of the individual, I find the above listed individual is: | | | | | |
| Physically able to give adequate care to foster/adoptive child(ren) with no restrictions and no jeopardy to individual’s health. | | | | | |
| Physically able to give adequate care to foster/adoptive child(ren) with the following supports: | | | | | |
| Not physically able to give adequate care to foster/adoptive child(ren). Explain: | | | | | |
| If the individual is an adoptive applicant, on the basis of my findings, as indicated above and my knowledge of the individual, I find the above-listed individual:  **IS**  **IS NOT** in such physical condition that it is reasonable to expect him/her to live to the child(ren)’s majority and have the energy and other abilities needed to fulfill parental responsibilities. | | | | | |
| medical care provider’s signature:  **X** | | Telephone Number:  (     )       - | | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’s Address: | | | | | |
| physician’S stamp: | | | | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | | | |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**HOUSEHOLD MEMBER MEDICAL REPORT (PART TWO)**

Instructions:

**Applicant(s):** There are three sections to this form. **Section 1** is to be completed by the applicant if household member is under 18 years of age or by the household member if 18 years of age or older. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant(s). Provide one form per household member.

|  |  |  |  |
| --- | --- | --- | --- |
| **PART 2 - SECTION 1: household member’S information** | | | |
| Last, First, Middle Initial: | | DATE OF BIRTH:        /       / | Telephone Number:  (     )       - |
| NAME OF applicant(S): | RelationSHIP to APPLICANT(S): | | |
| Address of applicant(S): | | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | | |
| household member Or Parent/guardian if Household Member is under 18 years of age Signature:  **X** | | | DATE:        /       / |
| The above-named individual(s) is residing in the home of an individual(s) who is seeking to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must show that each member of the household is in good physical and mental health and free from communicable diseases. | | | |

|  |
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| **SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME: |
| AGENCY’S ADDRESS: |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER): |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member of an applicant(s). | | | |
| **Please respond to each of the following to the best of your knowledge:** | | | |
| Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment? | | | No  Yes |
| Is this individual currently taking medications? | | | No  Yes |
| Have you ever referred this individual to other medical services, mental health services, or treatment for alcohol/substance abuse? | | | No  Yes |
| Does the individual have any communicable disease, infection, illness, or any physical condition that might affect the proper care of children? | | | No  Yes |
| Please provide an explanation for any “Yes” response. | | | |
| Is the above-listed individual in good physical and mental health, and free from communicable diseases? | | | No  Yes |
| Please provide an explanation for “No” response. | | | |
| MEDICAL CARE PROVIDER’S SIGNATURE:  **X** | Telephone Number:  (     )       - | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’s Address: | | | |
| physician’S stamp: | | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**FOSTER/ADOPTIVE APPLICANT MEDICAL REPORT (PART ONE)**

Instructions:

**Applicant:** There are three sections to this form. **Section 1** is to be completed by the applicant. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for the applicant.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant.Provide one form per applicant.

|  |  |  |
| --- | --- | --- |
| **PART ONE - Section 1: APPLICANT’S INFORMATION** | | |
| NAME OF APPLICANT: | | |
| Last, First, Middle initial: | DATE OF BIRTH:       /       / | Telephone Number:  (     )       - |
| Address of applicant: | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | |
| APPLICANT’S SIGNATURE:  **X** | | |
| The above-named applicant has applied to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for certification or approval is submitted to the certifying or approving agency. | | |

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| **SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME: |
| AGENCY’S ADDRESS: |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER): |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each applicant. | | | | | |
| **Please respond to each of the following to the best of your knowledge:** | | | | | |
| Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment? | | | | | No  Yes |
| Is this individual currently taking medications? | | | | | No  Yes |
| Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? | | | | | No  Yes |
| Please provide an explanation for any “Yes” response. | | | | | |
| **GENERAL HEALTH REVIEW OF APPLICANT** | | | | | |
| Physical Exam Date:        /       / | Height:        : | Weight:        LBS | Blood Pressure:       / | | |
| Vision: | | Hearing: | | | |
| Cardiovascular: | | Pulmonary: | | | |
| GastroIntestinal: | | Endocrine: | | | |
| Nervous System: | | Muscular/Skeletal: | | | |
| Skin: | | | | | |
| Results of tuberculin test and/or chest X-ray (must be current) | | | | | |
| Date Mantoux (tuberculin) test given:        /       / | | Results of Mantoux test: | | | |
| If chest X-ray or additional tests are required, provide test, date, and results below: | | | | | |
| Does the individual have any communicable disease, infection, illness, or any physical condition that might affect the proper care of child(ren)?  No  Yes  Explain: | | | | | |
| **FINDINGS** | | | | | |
| On the basis of my findings, as indicated above, and my knowledge of the individual, I find the above listed individual is: | | | | | |
| Physically able to give adequate care to foster/adoptive child(ren) with no restrictions and no jeopardy to individual’s health. | | | | | |
| Physically able to give adequate care to foster/adoptive child(ren) with the following supports: | | | | | |
| Not physically able to give adequate care to foster/adoptive child(ren). Explain: | | | | | |
| If the individual is an adoptive applicant, on the basis of my findings, as indicated above and my knowledge of the individual, I find the above-listed individual:  **IS**  **IS NOT** in such physical condition that it is reasonable to expect him/her to live to the child(ren)’s majority and have the energy and other abilities needed to fulfill parental responsibilities. | | | | | |
| medical care provider’s signature:  **X** | | Telephone Number:  (     )       - | | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’s Address: | | | | | |
| physician’S stamp: | | | | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | | | |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**HOUSEHOLD MEMBER MEDICAL REPORT (PART TWO)**

Instructions:

**Applicant(s):** There are three sections to this form. **Section 1** is to be completed by the applicant if household member is under 18 years of age or by the household member if 18 years of age or older. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant(s). Provide one form per household member.

|  |  |  |  |
| --- | --- | --- | --- |
| **PART 2 - SECTION 1: household member’S information** | | | |
| Last, First, Middle Initial: | | DATE OF BIRTH:        /       / | Telephone Number:  (     )       - |
| NAME OF applicant(S): | RelationSHIP to APPLICANT(S): | | |
| Address of applicant(S): | | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | | |
| household member Or Parent/guardian if Household Member is under 18 years of age Signature:  **X** | | | DATE:        /       / |
| The above-named individual(s) is residing in the home of an individual(s) who is seeking to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must show that each member of the household is in good physical and mental health and free from communicable diseases. | | | |

|  |
| --- |
| **SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME: |
| AGENCY’S ADDRESS: |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER): |

|  |  |  |  |
| --- | --- | --- | --- |
| **SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member of an applicant(s). | | | |
| **Please respond to each of the following to the best of your knowledge:** | | | |
| Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment? | | | No  Yes |
| Is this individual currently taking medications? | | | No  Yes |
| Have you ever referred this individual to other medical services, mental health services, or treatment for alcohol/substance abuse? | | | No  Yes |
| Does the individual have any communicable disease, infection, illness, or any physical condition that might affect the proper care of children? | | | No  Yes |
| Please provide an explanation for any “Yes” response. | | | |
| Is the above-listed individual in good physical and mental health, and free from communicable diseases? | | | No  Yes |
| Please provide an explanation for “No” response. | | | |
| MEDICAL CARE PROVIDER’S SIGNATURE:  **X** | Telephone Number:  (     )       - | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’s Address: | | | |
| physician’S stamp: | | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**REQUEST FOR STAFF EXCLUSION LIST CHECK**

Child Day Care Programs

|  |  |  |
| --- | --- | --- |
| Program Name: |  | Facility ID Number: |

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked before an individual has regular and substantial contact with children in child day care programs. This includes providers, staff, and volunteers. It also includes residents 18 years of age and older living in group family day care and family day care homes.

**Instructions:**

* This form is used to check the Justice Center’s Staff Exclusion List (SEL).
* The requirement applies only to those who begin their association with the program after 6/30/13.

To determine where to submit this form, find the type of program and the individual’s position in the list below.

|  |  |
| --- | --- |
| **Type of Program / Position** | **Where to submit** |
| **Family Day Care, Group Family Day Care and Small Day Care Center** | The licensor/registrar of the program. |
| **Day Care Center and School Age Child Care Directors** | The licensor/registrar of the program. |
| **Day Care Center and School Age Child Care Staff and Volunteers** | The director of the program. |

If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information in the space provided below. **PRINT clearly** to avoid delays in processing.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | | | | |
| **Last Name:** |  | | | | | |
| **Middle Initial:** | |  | | | | |
| **Social Security Number:** | | | |  | | |
| **Date of Birth** *Only if no SSN or Alien Reg. is available*: | | | | |  | |
| **Alien Registration Number** *Only If no SSN is available*: | | | | | |  |
| **Position applied for:** | | |  | | | |

OCFS-6022 (3/2015)

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**REQUEST FOR STAFF EXCLUSION LIST CHECK**

Child Day Care Programs

|  |  |  |
| --- | --- | --- |
| Program Name: |  | Facility ID Number: |

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked before an individual has regular and substantial contact with children in child day care programs. This includes providers, staff, and volunteers. It also includes residents 18 years of age and older living in group family day care and family day care homes.

**Instructions:**

* This form is used to check the Justice Center’s Staff Exclusion List (SEL).
* The requirement applies only to those who begin their association with the program after 6/30/13.

To determine where to submit this form, find the type of program and the individual’s position in the list below.

|  |  |
| --- | --- |
| **Type of Program / Position** | **Where to submit** |
| **Family Day Care, Group Family Day Care and Small Day Care Center** | The licensor/registrar of the program. |
| **Day Care Center and School Age Child Care Directors** | The licensor/registrar of the program. |
| **Day Care Center and School Age Child Care Staff and Volunteers** | The director of the program. |

If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information in the space provided below. **PRINT clearly** to avoid delays in processing.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | | | | |
| **Last Name:** |  | | | | | |
| **Middle Initial:** | |  | | | | |
| **Social Security Number:** | | | |  | | |
| **Date of Birth** *Only if no SSN or Alien Reg. is available*: | | | | |  | |
| **Alien Registration Number** *Only If no SSN is available*: | | | | | |  |
| **Position applied for:** | | |  | | | |

1. Applicant has the right to decline to answer questions in this section without any impact to their application. [↑](#footnote-ref-1)
2. “Sex” refers to a person’s biological and physiological characteristics. [↑](#footnote-ref-2)
3. “Gender Identity” refers to a person’s internal sense of themselves, regardless of anatomy. [↑](#footnote-ref-3)
4. “Sexual Orientation” refers to a person’s emotional, romantic and sexual attraction to other persons. [↑](#footnote-ref-4)
5. Applicant has the right to decline to answer questions in this section without any impact to their application. [↑](#footnote-ref-5)
6. “Sex” refers to a person’s biological and physiological characteristics. [↑](#footnote-ref-6)
7. “Gender Identity” refers to a person’s internal sense of themselves, regardless of anatomy. [↑](#footnote-ref-7)
8. “Sexual Orientation” refers to a person’s emotional, romantic and sexual attraction to other persons. [↑](#footnote-ref-8)