APPLICATION FOR THERAPEUTIC FOSTER CARE

Prospective Foster Parent's Name: ______________________________
(Last, First)

____
(Maiden Name or Alias)

Date of Birth: ____________________ ☐ Male ☐ Female

Marital Status: ____________________ **Language:** ____________________

Are you a US Citizen? ☐ Yes ☐ No

Education: ______________________________

E-Mail: ______________________________

Prospective Foster Parent's Name: ______________________________
(Last, First)

____
(Maiden Name or Alias)

Date of Birth: ____________________ ☐ Male ☐ Female

Marital Status: ____________________ **Language:** ____________________

Are you a US Citizen? ☐ Yes ☐ No

Education: ______________________________

E-Mail: ______________________________

Home Address: ______________________________
Street Address Town/City State Zip Code County

Home Telephone Number: ____________________

Cell Phone Number(s): ______________________________

Employer Name and Telephone Number: ______________________________

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1) **Are you and your family self-supporting without the income of boarding children?** ☐ Yes ☐ No

2) **Are you a certified foster parent now?** ☐ Yes ☐ No
If yes, with what agency? ______________________________

3) **Have you ever been a certified foster parent in the past?** ☐ **Yes** ☐ **No**

If yes, with what agency and the dates of certification? ______________________________

4) **Have you ever adopted a child?** ☐ **Yes** ☐ **No**

If yes, from what agency did you adopt? ______________________________

5) **Are you applying to foster for a specific child?** ☐ **Yes** ☐ **No**

If yes, what is the child's name? ______________________________

Note: *Select all acceptable characteristics of the children that you will consider for placement. You may choose more than one entry in each area.*

AGE: ☐ Infant ☐ Infant under 2 ☐ 2-5 yrs ☐ 6-7 yrs ☐ 8-9 yrs ☐ 10-13 yrs ☐ 13 & over

SEX: ☐ Male ☐ Female ☐ Either **ETHNICITY:** ______________________________

If you will consider a child with special needs, select the types of disabilities that you will consider:

Physical:	☐ Severe	☐ Moderate	☐ Mild
Mental:	☐ Severe	☐ Moderate	☐ Mild
Emotional / Behavioral:	☐ Severe	☐ Moderate	☐ Mild
Learning:	☐ Severe	☐ Moderate	☐ Mild

Would you be interested in a sibling group? ☐ Yes ☐ No

If yes, what size sibling group? ☐ 2 ☐ 3 ☐ 4+

PLEASE LIST ALL HOUSEHOLD MEMBERS OTHER THAN THOSE WHO ARE APPLYING AS FOSTER PARENTS:

Name	DOB	Sex	Education (highest grade completed)

Signatures (if a couple, both must sign):

______________________________ Date

______________________________ Date