**Kennedy-Donovan Center**
**Intensive Foster Care Program**
**LIFT Program**

# Family Resource Application

## Cover Sheet

Check type of family resource:
- ☐ **KINSHIP**
- ☐ **CHILD-SPECIFIC**
- ☐ **UNRESTRICTED**

Kennedy-Donovan Center 508-997-5875
(Agency Name) (Telephone)

376 Nash Rd. New Bedford MA 02746
(Address)

Check program you are interested in:
- ☐ **FOSTER CARE**
- ☐ **ADOPTION**

_____
(Date)

Please provide information as indicated. If you need assistance, please contact: _____

**APPLICANT:** _____
(Last) (First) (Middle) (Maiden, if applicable)

**ANY OTHER NAME USED:** _____

**CO-APPLICANT NAME:** _____
(Last) (First) (Middle) (Maiden, if applicable)

**ANY OTHER NAME USED:** _____

**ADDRESS:** _____
(Number and Street) (Town) (State) (Zip Code)

**TELEPHONE #s:** _____ _____ _____
(Area Code & Home #) (Area Code & Work # for Applicant) (Area Code & Work # for Co-Applicant)

_____ _____
(Cell/Mobile # for Applicant) (Cell/Mobile # for Co-Applicant)

**EMAIL ADDRESSES:** _____ _____
(For Applicant) (For Co-Applicant)

**EMERGENCY TELEPHONE** [Please provide the name and telephone number of person(s) through whom you can be reached in an emergency.]**:**

_____ _____ _____
(Name of Emergency or Telephone Contact) (Area Code & #) (Hours Available)

**DIRECTIONS TO YOUR HOME** (From above-named DSS office/agency)**:** _____

_____

_____

_____

**LANGUAGE(S):** **Spoken in household** Primary:_____ Other: _____

**Written comprehension** Primary:_____ Other: _____

## Section A: INITIAL ELIGIBILITY SCREENING INFORMATION

***PLEASE NOTE: The following information will be used by the Department to determine whether you meet the basic requirements for applying to become as a foster or adoptive family. IF NOT APPLICABLE, WRITE "N/A." USE ADDITIONAL PAPER IF NECESSARY. APPLICANT(S) INFORMATION:***

| | APPLICANT | CO-APPLICANT |
|---|---|---|
| SEX | ☐ Male ☐ Female | ☐ Male ☐ Female |
| BIRTHDATE | | |
| PLACE OF BIRTH | | |
| SOCIAL SECURITY # | | |
| COUNTRY OF CITIZENSHIP | | |
| IF NOT US CITIZEN, US IMMIGRATION STATUS | | |
| EDUCATION (Last Grade Completed) | | |
| CURRENT MARRIAGE Date | | |
| PREVIOUS MARRIAGE Date<br>Date Ended | | |
| CURRENT EMPLOYMENT: Type | | |
| Hours/Days Worked | | |
| Date Employment Began | | |
| Contact for Verification:<br>Employer Name/ Telephone # | | |
| INCOME PER YEAR—List Sources (inc. TAFDC/welfare, SSI or SSA for self/ others), Amount per Year, and Contact for Verification (Name and Telephone #)<br><br>TOTAL | | |

2. **FAMILY / HOUSEHOLD MEMBERS INFORMATION:**

   Please provide the following information for *ALL* additional family members including children and any other individuals living in your home:

| FULL NAME | SEX | BIRTHDATE | SOCIAL SECURITY # | LIVING AT HOME? | SCHOOL GRADE OR OCCUPATION |
|---|---|---|---|---|---|
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |

3. Please provide the following information for other individuals age 14 or older who spend substantial time at the home, especially those who stay overnight or provide child care in the home:

| FULL NAME | SEX | BIRTHDATE | SOCIAL SECURITY # | NATURE OF CONTACT | SCHOOL GRADE OR OCCUPATION |
|---|---|---|---|---|---|
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |
| _____ | _____ | ____/____/____ | _____ | _____ | _____ |

4. Is someone providing family-based child care in the home? YES ☐ NO ☐ If yes, please list name of person(s) providing family-based child care services, the number and ages of children who are being cared for, and enclose a copy of the child care license:

   _____

5. Is someone caring for a disabled individual in the home? YES ☐ NO ☐ If yes, please explain who is receiving care, why and who is providing care; identify the agency, if any, that is supporting the care being provided:

6. **CHILD CARE PLAN:** Please provide names of any person(s) other than yourself or your co-applicant who will provide day care and supervision in your home for any child(ren) placed with you and describe any other child care or day care services you plan to use, or will need, to assist you in providing care and supervision:

   ***Please be aware that no pre-school age child in DCF foster/pre-adoptive care may be placed in work-related child care for more than 50 hours per week (or 25 hours per week for child in grade 1 or up).***

7. **HOUSING:** Own ☐ Rent ☐ How long at current address? _____

   Name/telephone # of contact for verification: _____

   Previous address: _____

   How long at previous address? _____

   Name/telephone # of contact for verification: _____

8. **ANIMALS AT HOME:** Do you have any? YES ☐ NO ☐ If yes, please list type, and if dogs, indicate breed and purpose:

**HISTORY AS FOSTER CARE OR ADOPTIVE FAMILY:**

9. Have you applied to this or any other agency for foster care or adoption? YES ☐ NO ☐ If yes, please list agency name(s) and date(s) of application:

| NAME OF AGENCY | DATE OF APPLICATION |
|---|---|
| | |
| | |

10. Are you, or any member of your household, now providing foster or pre-adoptive care? YES ☐ NO ☐ If yes, please list the name of person(s) providing foster/pre-adoptive care and identify the placement agency:

| HOUSEHOLD MEMBER'S NAME | NAME OF AGENCY |
|---|---|
| | |
| | |

***Please be aware that DCF will conduct a search of Massachusetts court, Sexual Offender Registry Board, and child welfare records to determine if you, or any member of your household, has a history of previous involvement with DCF or criminal conduct which would make your home unsuitable for the placement of children. If you have previously lived in a state other than Massachusetts or in a U.S. territory or on an Indian reservation, you are requested to provide comparable information from that state or other authority's court and child welfare systems. Please also be aware that DCF may make collateral contacts with any other individuals regarded by DCF as useful to the determination of whether you are eligible to apply to become a foster or adoptive family for DCF.***

***FAILURE TO ANSWER THE FOLLOWING QUESTIONS OR TO PROVIDE THE INFORMATION REQUESTED REGARDING ANY HISTORY OF CHILD ABUSE OR NEGLECT OR CRIMINAL CONDUCT IS CAUSE FOR MANDATORY DISQUALIFICATION FROM BECOMING A KDC or DCF FOSTER OR ADOPTIVE FAMILY.***

11. Have you or any member of your family or household ever been charged with, or convicted of, a crime (as an adult or as a juvenile, including any incident where a record was sealed, or the disposition was dismissed, continued without a finding, vacated, filed or not processed)? Has a temporary or permanent protective order ever been issued against you or a member of your household [i.e., under MGL c. 208 (divorce); MGL c. 209 (abandonment in marriage); or MGL c. 209A (abuse prevention)]? YES ☐ NO ☐

    If yes, please explain:

_____

_____

_____

_____

_____

12. Have you or any member of your family or household ever been a client of this Department, as an adult or as a child (e.g., a recipient of CRA or voluntary services), or the subject of a 51A (i.e., a report of child abuse or neglect), or have you received comparable services from another state, U.S. territory or tribal authority? YES ☐ NO ☐

    If yes, please explain and provide approximate dates of service: _____

    _____

    _____

    _____

13. **FIREARMS:** Do you or any member of your household have firearms? YES ☐ NO ☐ If yes, please provide a copy of the firearm identification card and/or pistol permit.

## Section B: LICENSE STUDY INFORMATION

☛ ***PLEASE ATTACH A PHOTOGRAPH OF YOUR FAMILY TO THIS APPLICATION***

***[NOTE FOR ADOPTION APPLICANT(S): One certified copy each of the birth certificate, and any marriage licenses and divorce decrees, of applicant and co-applicant are required for finalization of adoptions.]***

14. **HOUSING:** Do you have homeowner or renter insurance? YES ☐ NO ☐ If yes, name of insurance company: _____

**HEALTH HISTORY:**

15. Have you or any member of your household been treated for any serious or chronic illness, drug or alcohol abuse? YES ☐ NO ☐ If yes, please identify:

| HOUSEHOLD MEMBER'S NAME | TREATMENT PROVIDER'S NAME | ADDRESS | TELEPHONE # | TREATMENT TYPE / DATES |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

16. Do you or any member of your household have any other current medical problems or conditions that the Department should be aware of? YES ☐ NO ☐ If yes, please identify:

| HOUSEHOLD MEMBER'S NAME | TREATMENT PROVIDER'S NAME | ADDRESS | TELEPHONE # | CONDITION / DATE OF ONSET |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

17. **DRIVER INFORMATION:** Only licensed, insured drivers are able to transport children in DCF care or custody. Please list all household members, including applicant and co-applicant, with a valid driver's license and insurance:

| DRIVER'S NAME | LICENSE NUMBER | EXPIRATION DATE | STATE |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

18. **REQUIRED REFERENCES:** Please list references below. Please provide **complete** address and telephone number for each reference.

| NAME | ADDRESS NUMBER & STREET<br>CITY, ZIP CODE<br>TELEPHONE # (INC. AREA CODE) | NAME(S) OF PERSON(S) REFERENCE IS FOR | OFFICE USE ONLY<br>Date Sent | <br>Date Rec'd. |
|---|---|---|---|---|
| **MEDICAL Reference(s)—**One required for each household member | | | | |
| **EMPLOYER Reference(s)**—One required for each Applicant and one required for Head of Household, if she/he is not an Applicant | | | | |
| **SCHOOL/CHILD CARE PROGRAM Reference(s)—**One required for each school age child living in the home and each younger child who participates in a pre-school or child care program | | | | |
| **PERSONAL References—**2 required for family; can be from clergy, relative, friend, or other | | | | |

I hereby apply to be a foster or adoptive parent. I agree to participate in the DSS approved pre-licensing training and parenting group for preparation and assessment that is required for the type of license I am seeking. I further agree to release any information necessary for this application/evaluation and to allow an inspection of my home. I understand that DCF will obtain references, make inquiries regarding any child abuse, sexual offender history, or criminal record, and that any falsification or withholding of information on this application may be grounds for my denial as a foster or adoptive parent. I agree that DCF may make collateral contacts with any individuals named in this application, as well as other individuals regarded by DCF as useful to evaluation of this application. I understand it is my obligation to report any change in circumstances regarding housing, health, household membership (including all individuals who spend substantial time—especially overnights—in my home), pets/animals and/or other background information provided in this application. I also understand that, upon licensing as a foster or adoptive parent, I become a "mandated reporter" and will be required to report suspected child abuse and neglect.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date