Kennedy-Donovan Center
Comprehensive Foster Care Program
LIFT Program

Family Resource Application

KENNEDY DONOVAN CENTER 774-206-8860 _____
(Agency Name) (Phone) (Date)

385 County Street, New Bedford, MA 02740
(Address)

Check program you are interested in:
☐ **FOSTER CARE**
☐ **SHARED LIVING**
☐ **LIFT**

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 DCF 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 Date Ended		
CURRENT EMPLOYMENT: Type		
Hours/Days Worked		
Date Employment Began		
Contact for Verification: 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 #) **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 childcare 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 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 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 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: _____

(continue next page)

_____

_____

_____

_____

_____

_____

_____

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

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 CITY, ZIP CODE TELEPHONE # (INC. AREA CODE)	NAME(S) OF PERSON(S) REFERENCE IS FOR	**OFFICE USE ONLY** Date Sent	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 parent. I agree to participate in the DCF 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 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**