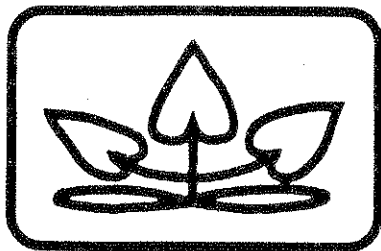


SENECA NATION HEALTH DEPARTMENT



CHILD AND FAMILY SERVICES PROGRAM

Allegany Office - Lionel R. John Health Center
987 R.C. Hoag Drive - Salamanca, NY
Mailing Address: P.O. Box 500
Salamanca, NY 14779-0500
Phone: (716) 945-5894
Toll Free: 1-800-618-4616
Fax: (716) 945-7881

Cattaraugus Office - CHWC
Health and Wellness Center
36 Thomas Indian School Drive
Irving, NY 14081
Phone: (716) 532-4093
Toll Free: 1-800-894-1162
Fax: (716) 532-3762

Dear Applicant,

Thank you so much for your interest in protecting and helping Native Youth. As a foster parent you will offer much value to the lives of children and parents alike. Enclosed you will find an application packet. You will also find instructions on how to complete the forms. If at any time during this process you are having trouble with the application or have questions, do not hesitate to contact the Home Finder/Educator on either territory. The Salamanca number is (716)945-5894 and the Cattaraugus number is (716)532-4035. We look forward to working with you!

Sincerely,

SNI Child and Family Services

Instructions

Please read all questions carefully before responding.

- Pages 1-7: Must be filled out for the household.
- Pages 8-13: Two copies are provided; one to be completed by each applicant.
- Page 14-15: One form must be completed by your child's doctor and the other by your child's school. The forms will be filled out in regards to all of your children. If you have younger and older children in different schools or doctors offices, you will need to request additional copies.
- The Criminal Background Form must be notarized before bringing it back to the office.
- When filling out the State Central Registry Clearance form, be sure that your addresses are consecutive. If there are any lapses of time the form will be sent back to us rejected. Sometimes it is difficult to recall former addresses, just do your best.

Any costs incurred for background checks are the responsibility of the foster parent. You may be reimbursed at the time you have successfully completed the certification process and obtained your first placement.

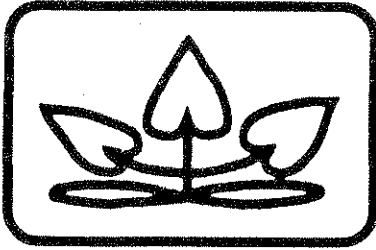
Additional Information:

Once you have turned in your application packet, all of your references will be contacted and background checks completed. After the background checks come back, you will then complete either a 10 week program called Group Preparation and Selection of Foster and or Adoptive Families, Model Approach to Partnerships in Parenting (GPS MAPP) or Deciding Together. The class that you participate in will be up to the discretion of the agency.

Upon successful completion of the program, you will have a Home Study conducted by the Home Finder/Educator or MAPP instructor.

Once all of the information is gathered and completed, our team will review the information and you will be contacted as to the outcome.

Annually foster parents will undergo re-certification. Foster parents are required to gain a minimum of 12 hours of additional training per year as well as complete updated background check and home study information. Training will be provided by our agency at minimal or no cost.



SENECA NATION HEALTH DEPARTMENT

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**Seneca Nation of Indians
Child and Family Services
Adoption and Foster Care Application**

PLEASE PRINT

Please check one of the following:

- Adoption only Foster License (Non-Relative)

SPECIFIC CHILD ONLY:

<input type="radio"/> Foster License- Relative
<input type="radio"/> Foster License- Non-Relative Child Specific
Name(s) of children for whom you are already providing care or for whom you want to provide care-(Relative/Child specific-not biological)
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
What is your relationship to/with child(ren)?

6. Please list ALL other members of your household:

<u>Last Name</u>	<u>First</u>	<u>Middle</u>	<u>DOB</u>	<u>Relationship to you</u>

7. Do you require any physical accommodation and/or assistance to help you participate in the Child and Family Services training process for foster/adoptive parents?

Applicant #1:

Applicant #2:

Yes No

Yes No

If so, what accommodations/assistance would you need?

8. Please provide the following information regarding your employment for the past 3 years and financial situation.

Applicant #1:

<u>Employer:</u>	<u>Address</u>	<u>Start/End Date:</u>	<u>Position:</u>	<u>Work days/Hours</u>

Applicant #2:

<u>Employer:</u>	<u>Address:</u>	<u>Start/End Date:</u>	<u>Position:</u>	<u>Work days/Hours</u>

Do you have a checking account?

Applicant #1: Yes No Applicant #2: Yes No

Do you have a savings account?

Applicant #1: Yes No Applicant #2: Yes No

Is your household income sufficient to meet your family's needs and care for an additional child(ren)?

Yes No

9. Do you have any other source of income?

Applicant #1: Yes No Applicant #2: Yes No

If yes please explain:

10. Have you, your partner, your child(ren), or any member of your household ever been the subject of in indicated report by Child Protective Services in NY or any other state?

Yes No

If yes please explain:

11. Have you or your partner ever been licensed for day care, foster care or adoption; or have you ever applied to do so?

Yes No

If yes please explain:

12. Have you or another member of your household ever received services from probation or parole?

Yes No

If yes please explain:

13. Have you, your partner, your children, or any member of your household ever been arrested, or charged by the police or been arraigned, indicted, or convicted of any offense in any state?

Yes No

If yes please explain:

14. Have you, your partner, your children, or any member of your household ever received counseling from or had any previous involvement with a Human Service Agency, Mental Health Clinic/Facility, a private therapist, Family Service Agency, Counseling Center, Adoption agency, etc.?

Yes No

If yes please explain:

15. Do you or your partner have any chronic illness or handicap that may affect your capacity to parent a child, who may be physically, emotionally or behaviorally challenging?

Yes No

If yes please explain:

16. Please list below all physicians with whom members of your family are involved:

Physician

Address

Family Member

Reason

17. Personal References:

Please list three (3) persons (Non-Relative) who have known you for at least two years and can comment on your family's lifestyle and values. Please inform them that they will be used as references and will be receiving a letter from SNI Child and Family Services, requesting a personal reference response. Also, please ask them to return their response to the Program as soon as possible, as this will help us expedite processing your application.

<u>Full Name</u>	<u>Complete Mailing Address and Zip Code</u>
1. _____	_____
2. _____	_____
3. _____	_____

18. Housing and Safety Factors

*Do you own your home? Yes No

*In what type of housing do you live? Single Family Multi-family Section 8
 Public Housing Subsidized housing

*How many rooms are in your home? _____ How many bedrooms? _____

*Was your residence built after 1978? Yes No

*Is your home lead safe? Yes No Unsure

*What is your water source? Well Spring Town/City

*Do you own a gun? Yes No

If Yes, where and how is it stored, as to be inaccessible to children?

*Is there a swimming pool on the property? Yes No

If Yes, is it securely fenced? Yes No

***Please list your pets:**

None

Type of Pet:	Licensed? (Y/N)	Up to date on Rabies Inoculations? (Y/N)

How do your pets relate with children?

19. Matching Factors- To be completed by Adoption Applicants and Foster Care Non-Relative Applicants. (Relative and Child-specific Foster Care Applicants **do not** need to complete this section.)

What is your preference regarding the child/children for whom you would like to be considered as a foster or adoptive resource?

Age Range: From _____ To _____

Gender: Male Female No Preference

Sibling Group: Yes No Undecided

Please check the degree of handicapping conditions you feel you might consider.

Physical: None Mild Moderate Severe

Emotional: None Mild Moderate Severe

Intellectual: None Mild Moderate Severe

Please Read Carefully

I/We, the undersigned, attest that the information contained in this application is complete and accurate. I/We understand that any false representation on this application may be cause for denial of the license, which is sought or immediate revocation of any license if it has been issued. I/We further understand that all members of my/our household will be cleared through the local law enforcement authorities and the records of the State Central Registry.

Applicant #1

Date

Applicant #2

Date

Motivation to Foster or Adopt
(Use back of paper if necessary)

Name: _____

1. How long did you think about fostering or adopting before applying and who spoke of it first?
2. How did you hear of this program?
3. Why do you want to foster or adopt a child through this Program?
4. What experience have you had directly or indirectly with foster care or adoption?
5. Many families experience difficulties in conceiving or maintaining a pregnancy. Is this something that you have experienced?
 Yes No

If yes, have you taken any steps to alleviate these difficulties? Yes No
Are any of these issues a major factor in your decision to Foster or Adopt?
 Yes No
6. (If applicable) What understanding do your present children have about foster care or adoption?
7. Many people have experienced trauma in their own lives, such as childhood abuse, sexual abuse, and domestic violence. Have you ever experienced or witnessed any of these?
 Yes No If yes, briefly explain:
8. What strengths do you bring to the parenting experience?
9. In what areas might you need help in parenting a child placed with you?
10. Describe any experiences you may have had with child care.

Motivation to Foster or Adopt
(Use back of paper if necessary)

Name: _____

11. How long did you think about fostering or adopting before applying and who spoke of it first?
12. How did you hear of this program?
13. Why do you want to foster or adopt a child through this Program?
14. What experience have you had directly or indirectly with foster care or adoption?
15. Many families experience difficulties in conceiving or maintaining a pregnancy. Is this something that you have experienced?
 Yes No
If yes, have you taken any steps to alleviate these difficulties? Yes No
Are any of these issues a major factor in your decision to Foster or Adopt?
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16. (If applicable) What understanding do your present children have about foster care or adoption?
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 Yes No If yes, briefly explain:
18. What strengths do you bring to the parenting experience?
19. In what areas might you need help in parenting a child placed with you?
20. Describe any experiences you may have had with child care.

Drug/Alcohol History:

1. Have you ever experienced the use of: Alcohol Marijuana Cigarettes
Other non-prescription drugs: _____
2. Have you experienced the use of this substance in the past 30 days:
 Alcohol Marijuana Cigarettes?
3. If you have experienced using alcohol or drugs, how old were you when you first had these experiences?
Alcohol _____ Marijuana _____ Cigarettes _____ Other _____
4. Did either of your parents drink? Mother Father
5. Did either of your parents use non-prescription drugs? Mother Father
6. Do you feel that the use of alcohol or drugs have caused a problem in your marriage/relationship? If so, please explain:

7. Do you ever feel bad about using alcohol? Yes No
8. Do you ever feel bad about using drugs? Yes No
9. Do you ever feel bad about things you do while under the influence of either substance?
 Yes No
10. Do you ever become annoyed at the criticism of your drinking or drug use?
 Yes No
11. Has anyone ever complained about your drinking or drug use? Yes No
12. Have you ever woke up the morning after drinking alcohol the night before and found that you could not remember a part of the evening before?
 Yes No
13. What kinds of things do you do for fun?

14. During these activities (#13) do you ever use?
Alcohol: Always Sometimes Never
Drugs: Always Sometimes Never

Signature: _____

Date: _____

Drug/Alcohol History:

1. Have you ever experienced the use of: Alcohol Marijuana Cigarettes
Other non-prescription drugs: _____
2. Have you experienced the use of this substance in the past 30 days:
 Alcohol Marijuana Cigarettes?
3. If you have experienced using alcohol or drugs, how old were you when you first had these experiences?
Alcohol _____ Marijuana _____ Cigarettes _____ Other _____
4. Did either of your parents drink? Mother Father
5. Did either of your parents use non-prescription drugs? Mother Father
6. Do you feel that the use of alcohol or drugs have caused a problem in your marriage/relationship? If so, please explain:

7. Do you ever feel bad about using alcohol? Yes No
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12. Have you ever woke up the morning after drinking alcohol the night before and found that you could not remember a part of the evening before?
 Yes No
13. What kinds of things do you do for fun?

14. During these activities (#13) do you ever use?
Alcohol: Always Sometimes Never
Drugs: Always Sometimes Never

Signature: _____
Date: _____

**MEDICAL HISTORY OF
PROSPECTIVE OR CERTIFIED
FOSTER PARENTS**

NAME OF FOSTER PARENT(S):
ADDRESS OF FOSTER PARENT(S):

NOTE: Physician should mail directly to:

SNI Child and Family Services licensing standards require all prospective and re-certifying foster parents complete this form. The medical report shall cover a physical examination of the applicant(s) and shall include a written statement from a physician regarding the foster family's general health, the absence of communicable disease, infection or illness or any physical conditions which might affect the proper care of a foster child. It shall include also the result of an intradermal tuberculin test and an additional report of chest x-rays where such test is positive.

Physician's Statement on the Family's General Health, etc.

RESULTS OF TUBERCULIN TEST:

DATE:

RESULTS OF CHEST X-RAYS

DATE:

On the basis of my findings, as indicated above, and my knowledge of the applicants and their family, I find that the above listed applicant(s) are/is physically

- ABLE to give adequate care for foster children
- NOT ABLE

Physicians Signature: _____ Date: _____

**MEDICAL HISTORY OF
PROSPECTIVE OR CERTIFIED
FOSTER PARENTS**

NAME OF FOSTER PARENT(S):
ADDRESS OF FOSTER PARENT(S):

NOTE: Physician should mail directly to:

SNI Child and Family Services licensing standards require all prospective and re-certifying foster parents complete this form. The medical report shall cover a physical examination of the applicant(s) and shall include a written statement from a physician regarding the foster family's general health, the absence of communicable disease, infection or illness or any physical conditions which might affect the proper care of a foster child. It shall include also the result of an intradermal tuberculin test and an additional report of chest x-rays where such test is positive.

Physician's Statement on the Family's General Health, etc.

RESULTS OF TUBERCULIN TEST:

DATE:

RESULTS OF CHEST X-RAYS

DATE:

On the basis of my findings, as indicated above, and my knowledge of the applicants and their family, I find that the above listed applicant(s) are/is physically

- ABLE to give adequate care for foster children
 NOT ABLE

Physicians Signature: _____ Date: _____

**MEDICAL HISTORY OF
PROSPECTIVE OR CERTIFIED
FOSTER PARENT'S CHILDREN**

NAME OF FOSTER PARENT(S):

ADDRESS OF FOSTER PARENT(S):

NOTE: Physician should mail directly to:

SNI Child and Family Services licensing standards require all prospective and re-certifying foster parents complete this form. The medical report shall cover a physical examination of the applicant's children and shall include a written statement from a physician regarding the foster family's general health, the absence of communicable disease, infection or illness or any physical conditions which might affect the proper care of a foster child. It shall also include whether children are current on inoculations, or any special health concerns.

One form may be completed for all children in the applicant's home.

Physician's Statement on the Family's General Health, etc.

On the basis of my findings, as indicated above, and my knowledge of the applicants and their family, I find that the above listed applicant(s) are/is physically

- ABLE to give adequate care for foster children
- NOT ABLE

Physicians Signature: _____ Date: _____

Seneca Nation of Indians
Child and Family Services
**SCHOOL HISTORY OF
PROSPECTIVE OR CERTIFIED
FOSTER PARENT'S CHILDREN**

I give permission for _____, to provide SNI Child and Family
(NAME OF SCHOOL)
Services with the following information on the children listed below:

Child(ren)'s Name and Date of Birth

Signature of Parent

1. Is (are) the child(ren) regular in attendance? Yes No

If the child(ren) has/have excessive illegal absences or is/are tardy frequently, please indicate:

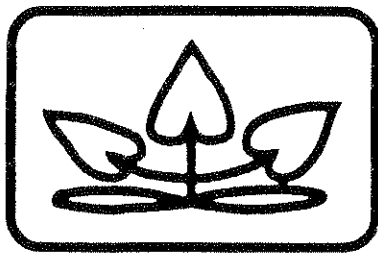
2. Do the parents attend and participate in parent/teacher conferences? Yes No

3. Are you aware of any reasons why this family should or should not be considered as foster or adoptive parents?

Signature

Date

SENECA NATION HEALTH DEPARTMENT



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Toll Free: 1-800-894-1162
Fax: (716) 532-3762

REQUEST FOR RELEASE OF CRIMINAL HISTORY RECORD INFORMATION

Name: _____

Maiden/Former Name: _____

Date of Birth: _____ Social Security No. _____

Address: _____

do hereby authorize the _____ County Sheriff's Department to
disclose my personal criminal record information to:

Seneca Nation of Indians
Child and Family Services Program
P.O. Box 500
Salamanca, NY 14779-0500

Date

Signature

State of _____)

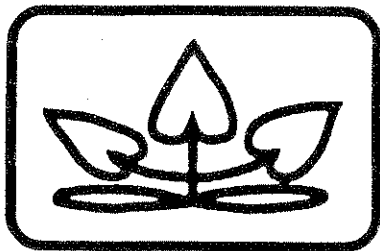
:s.s

County of _____)

On the _____ day of _____, 20___, before me personally appeared
_____, to me known to be the same person described
herein, and who has executed the foregoing instrument and acknowledged the
execution thereof.

Notary Public

SENECA NATION HEALTH DEPARTMENT



CHILD AND FAMILY SERVICES PROGRAM

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Name: _____

Maiden/Former Name: _____

Date of Birth: _____ Social Security No. _____

Address: _____

do hereby authorize the _____ County Sheriff's Department to disclose my personal criminal record information to:

Seneca Nation of Indians
Child and Family Services Program
P.O. Box 500
Salamanca, NY 14779-0500

Date

Signature

State of _____)

:s.s

County of _____)

On the _____ day of _____, 20____, before me personally appeared _____, to me known to be the same person described herein, and who has executed the foregoing instrument and acknowledged the execution thereof.

Notary Public

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER: AGENCY NAME: _____ AGENCY LIAISON: _____ STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form. FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List <i>RELATIONSHIP</i> in the fields below (see reverse side for instructions) Attach additional page if necessary.	

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
-----------------------	------	-----------------------	------

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE	SIGNATURE	DATE
-----------	------	-----------	------

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER: AGENCY NAME: _____ AGENCY LIAISON: _____ STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form. FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List <i>RELATIONSHIP</i> in the fields below (see reverse side for instructions) Attach additional page if necessary.	

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RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
MAIDEN/ALIAS				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

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PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
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SIGNATURE	DATE	SIGNATURE	DATE
-----------	------	-----------	------

