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.

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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:

○ Foster License- Relative

○ 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)?

_____

1. Applicant #1:

Last Name	First	Middle	Maiden	DOB

Social Security #	Race	Tribe	Clan	Religious Affiliation

2. Applicant #2:

Last Name	First	Middle	Maiden	DOB

Social Security #	Race	Tribe	Clan	Religious Affiliation

3. Address:

Number and Street	City or Town	Zip Code

Mailing address if different from above:

Number and Street	City or Town	Zip Code

Email address: _____

4. Telephone Number(s): **Applicant#1:** **Applicant #2:**

Home: _____ **Work:** _____ **Work:** _____
Cell #1: _____ **Cell #2:** _____

May we call you at work? Applicant #1: ○ **Yes** ○ **No** **Applicant #2:** ○ **Yes** ○ **No**

5. Please provide the following information about ALL your children including birth, step, and adoptive, regardless of age or current residence:

Last Name	First	DOB	Sex	Living with you? Y/N	Adopted Y/N

6. Please list ALL other members of your household:

Last Name	First	Middle	DOB	Relationship to you

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: ○Yes ○No

Applicant #2: ○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:

Employer:	Address	Start/End Date:	Position:	Work days/Hours

Applicant #2:

Employer:	Address:	Start/End Date:	Position:	Work days/Hours

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 yourhousehold 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 or 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.

	Full Name	Complete Mailing Address and Zip Code
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.)

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

Age Range: From _____ To_____

Gender: ○ **Male** ○ **Female** ○ **No Preference**

Sibling Group: ○ **Yes** ○ **No** ○ **Undecided**

<u>Please check the degree of handicapping conditions you feel you might consider</u>.

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?

    ○Yes ○No

16. (If applicable) What understanding do your present children have about foster care or adoption?

17. 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:

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
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: _____

Seneca Nation of Indians
Child and Family Services

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: _____

Seneca Nation of Indians
Child and Family Services

MEDICAL HISTORY OF PROSPECTIVE OR CERTIFIED FOSTER PARENTS

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

NOTE: Physician should mail directly to:

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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: _____

Seneca Nation of Indians
Child and Family Services

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

CHILD AND FAMILY SERVICES PROGRAM

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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

LDSS-3370 (Rev. 04/2011) FRONT

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 RELATIONSHIP 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

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ____

Other Household Members are (please print clearly):

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y

LDSS-3370 (Rev. 04/2011) FRONT

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 RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

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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
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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

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ______________________________

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ______________________________

Other Household Members are (please print clearly):

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y