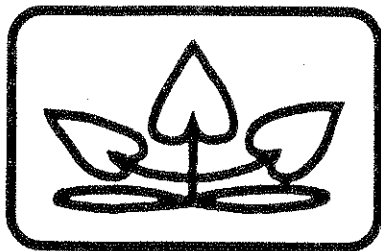


SENECA NATION HEALTH DEPARTMENT



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**CHILD AND FAMILY SERVICES PROGRAM**

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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.\***

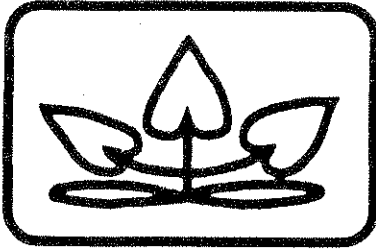
### Additional Information:

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

**CHILD AND FAMILY SERVICES PROGRAM**

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

**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:

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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:

---

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---

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:

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---

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

Yes  No

If yes please explain:

---

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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:

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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:

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---

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:

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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?**

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**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?  
 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: \_\_\_\_\_

**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:

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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: \_\_\_\_\_

**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

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\_\_\_\_\_  
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?

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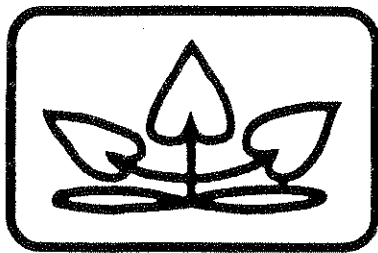
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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

SENECA NATION HEALTH DEPARTMENT



**CHILD AND FAMILY SERVICES PROGRAM**

Allegany Office - Lionel R. John Health Center  
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36 Thomas Indian School Drive  
Irving, NY 14081  
Phone: (716) 532-4093  
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 \_\_\_\_\_ )

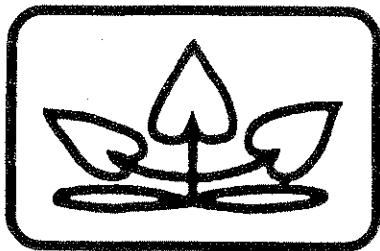
:s.s

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**

Allegany Office - Lionel R. John Health Center  
987 R.C. Hoag Drive - Salamanca, NY  
Mailing Address: P.O. Box 500  
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REQUEST FOR RELEASE OF CRIMINAL HISTORY RECORD INFORMATION

Name: \_\_\_\_\_

Maiden/Former Name: \_\_\_\_\_

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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*

<b>SCR USE ONLY</b>
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: <b>AGENCY NAME:</b> _____ <b>AGENCY LIAISON:</b> _____ <b>STREET ADDRESS:</b> _____ <b>CITY:</b> _____ <b>STATE:</b> _____ <b>ZIP CODE:</b> _____			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.  <b>FOR ALL CATEGORIES:</b> 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
<b>APPLICANT</b>				
<b>MAIDEN/ALIAS</b>				

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

<b>SCR USE ONLY</b>
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: <b>AGENCY NAME:</b> <b>AGENCY LIAISON:</b> <b>STREET ADDRESS:</b> <b>CITY:</b>			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.  <b>FOR ALL CATEGORIES:</b> 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.	
STATE:		ZIP CODE:		

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
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**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
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