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APPLICATION FOR FAMILY CARE PROVIDER CONTRACT

Family Name: **Date:**

Family Address: **City, State, Zip Code:**

Mailing Address (if different):

Applicant # 1 Phone Number(s): **Email Address:**

Applicant #2 Phone Number(s): **Email Address:**

Applicant #1			**Applicant #2**		
Full Name:			**Full Name**		
Other Names Used:			**Other Names Used:**		
SSN:		**Gender:**	**SSN:**		**Gender:**
Birthplace:		**DOB:**	**Birthplace:**		**DOB:**
DL #:	**State:**	**Exp. Date:**	**DL #:**	**State:**	**Exp. Date:**

Our therapeutic foster care serves youth with multiple behavioral, emotional, and/or mental health challenges. Please describe the type of youth you are willing to work with (check all boxes that apply and fill in blanks):

Age: from ____ - ____ years old **Number of youth:_____** **Male ☐** **Female ☐** **Gender Variant ☐**

Toilet Training Challenges (daytime or nighttime) ☐ **Sexual Acting Out ☐** **Physical Aggression ☐** **Fire Setting ☐**

Are there any behaviors you are especially qualified to work with?_____

Are there any behaviors you are not willing to work with?_____

Household Information

Both applicants: Please list all residences for the past five years (attach additional sheets if necessary):

Applicant #1

Dates (from-to)	Address, City, State, Country

Applicant #2

Dates (from-to)	Address, City, State, Country

Please list all members of the household (including yourself). Attach additional sheets if necessary.

Name	DOB	Gender	School/Occupation	Relationship to Applicant #1

Please list all of your children (applicant #1 & #2) not living with you. Include adult children. Attach additional sheets if necessary.

Name	DOB	Gender	Address	Relationship to Applicant #1

Please list all frequent visitors to your home. Attach additional sheets if necessary.

Name	DOB	Gender	Address	Relationship to Applicant #1

Home Environment

Type of Dwelling: ☐Single Family Home ☐Multi-Family Home ☐Mobile Home ☐Condominium ☐Apartment

Ownership of home: ☐Own ☐Rent ☐Lease
If you rent or lease, please list your Landlord/Rental Company Name/Contact info:_____

Is this your primary address? ☐Yes ☐No **Is your home wheelchair accessible?** ☐Yes ☐No **Water Supply:** ☐Public ☐Private

What is the square footage (in cubic feet):_____ **If applicable, what is the lot size?** _____

Please describe any unique property features your residence contains (examples: pools, ponds, trampolines, outbuildings, workshops, etc.):_____

Sleeping Arrangements: Please indicate what room or rooms you have available for foster youth, estimate the size, where it is in proximity to your room and if they would be sharing a room with biological youth: _____

Please list all animals on property (include animal type and if they have a current rabies vaccination, if applicable):

_____

Are any animals potentially dangerous to children of certain ages or with specific behaviors? ☐Yes ☐No

Do you store firearms and/or other weapons on your property? ☐Yes ☐No

Local School District (if known):_____

Please list nearest Medical and Mental Health facilities. Include mileage from your residence (if known):_____

Please list the nearest community-based recreational activities for youth (examples: Boys and Girls Club, Museums, Library, etc.) Include mileage from your residence (if known):_____

Care Provider History

Applicant #1
Employment History

Are you employed? ☐Full time ☐Part time ☐Retired

☐Not Currently Employed ☐Never Been Employed

Present Employer:

Business Phone Number:

Type of Business:

Your Position:

May we contact you at work?

What hours are you at work (including travel time)?

What is your source of income if you are not employed?

Applicant #2
Employment History

Are you employed? ☐Full time ☐Part time ☐Retired

☐Not Currently Employed ☐Never Been Employed

Present Employer:

Business Phone Number:

Type of Business:

Your Position:

May we contact you at work?

What hours are you at work (including travel time)?

What is your source of income if you are not employed?

Applicant #1
Educational History

High School/GED (include graduation year):

Degrees, certificates and/or applicable training:

Applicant #2
Educational History

High School/GED (include graduation year):

Degrees, certificates and/or applicable training:

What is your household combined total monthly income (after taxes)?:_____

What is your household combined total monthly expenses?_____

Please list the amounts and kind of any government or financial assistance that you receive (Examples: Section 8, Food Stamps, SSI, Disability, Student Loans etc…)

Previous Care Experience

Have you ever been certified as a foster parent or to provide in-home care? ☐Yes ☐No

Have you ever applied to be a foster parent? ☐Yes ☐No **Are you currently certified to provide foster care?** ☐Yes ☐No

Please list the agencies with which you have been licensed *or* applied to provide foster care:

Agency/Branch	Name of Certifier and Contact Information	Certification Dates From/To

If your certification or license to be a foster parent or provide in-home care was ever suspended or terminated, please describe the circumstances (include dates and additional pages if necessary):_____

Health

Do you or any members of the household have a history of trauma in any circumstance? ☐Yes ☐No
If yes please describe which members of the household have had trauma experiences, when, and what the circumstances were:

Do you or any members of the household currently drink alcohol under any circumstances? ☐Yes ☐No
If yes please describe which member(s) of the household drinks, how much, where they drink, and how often:

Do you or any members of the household currently smoke (tobacco or other products) under any circumstances? ☐ Yes ☐No
If yes please describe which member(s) of the household smoke, which product, where they smoke, and how often:

Please check all applicable health conditions that all people in your household (including yourself) have been affected by in the past five years to current:

☐Under a Doctor's Care for Medical or Mental Health Condition	☐Arthritis	☐Auto-Immune Disorders	☐Anxiety/Panic Attacks
☐High Blood Pressure	☐Chronic Pain	☐On Medication (Over-the-counter, herbal and/or prescribed)	☐Depression
☐Heart Disease	☐Mobility Issues	☐Kidney Problems	☐Post-Traumatic Stress Disorder
☐Heart Attack	☐Seizures	☐Bladder Problems	☐Other Mental Health Problems
☐Heart Failure	☐Asthma	☐Thyroid Conditions	☐Major Head Trauma
☐Migraines	☐Hospitalizations	☐Blood Clots	☐Addiction (Prescription or Illegal Drugs/Alcohol/Other)
☐Stroke(s)	☐Cancer	☐Pulmonary (Lung) Disorders	☐Participate(d) in Therapy/Counseling
☐Diabetes	☐Surgeries	☐Life-threatening Allergies	☐Receive Disability Benefits
	☐ Vision Issues	☐Other medical condition not listed	

If you marked any of the above boxes please explain the circumstances of each medical issue in the space below. Include dates and person(s) affected and how it impacts (if at all) your ability to provide therapeutic foster care. Attach additional sheets if necessary.

Please list all medications that all applicants currently take or are prescribed to take. Attach additional pages if necessary. Include over-the-counter and herbal medication.

Medication Name	Who takes this medication?	What is the dosage and how often do you take the medication?	Who is the Prescribing Doctor (if prescription)?	Why do you take this medication?	How many months or years have you been on this medication?

Criminal/Child Abuse History

Have you or anyone in your household ever been arrested or convicted of a crime or crimes, investigated for child abuse, or had children removed from your care (voluntarily or involuntarily)? ☐Yes ☐No

If you answered yes to the question above please fill out the box below explaining your history (attach additional sheets if necessary):

Name of Person	Description of arrest, charge, investigation and/or removal of children	Date of occurrence(s)	Circumstances

Relationship History

Please list all relationships you and your co-applicant (if applicable) have been in that have been in excess of six months, and/or resulted in cohabitation, and/or resulted in a child (attach additional sheets if necessary):

Name of applicant	Name of previous partner	Dates of Relationship (Start and End)	Name of child (if applicable, otherwise write N/A)	Reason Relationship Ended

Lifestyle

Please answer the following questions fully. Attach additional sheets if necessary.

Please describe your motivation for providing therapeutic foster care:

Please describe the daily routine (Sunday-Saturday) of all members (including yourself) of the household in the chart below. Be sure to include mealtime, times you are at work, times you are unavailable, recreational activities, and religious activities (if applicable). If it differs during different parts of the year (for example if school is not in session), please describe that as well:

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

How do you discipline children in your home?

Maple Star Oregon serves youth with behavioral, mental health, emotional and/or special needs. Please describe skills/attributes you and your family have that will be helpful for you to provide foster care with our agency:

What race(s)/ethnicity/culture(s) do you and your family identify or affiliate with?

What religions/spiritual beliefs do you and your family identify or affiliate with?

What community groups and/or recreational activities do you and your family participate in?

Self Care

How do you know when you and members of your household are experiencing stress?

How do you and members of your family deal with stress currently? Are there activities, services, people, places that help you cope with stress?

How do you and your family keep your bodies and minds healthy?

Foster Care Supports

*****Maple Star Oregon allows Family Care Providers to enlist people to act as Alternative Caregivers to help with youth in their home. Alternative Caregivers are allowed to supervise youth (in the Family Care Provider's home or a community setting) for up to 9 hours in a week (not during hours of sleep), but no more than 30 hours in a 90-day period. They must submit a background check, fingerprint card and Valid OR ID in order to be considered as an Alternative Caregiver. They may only transport youth in their vehicle if they have the appropriate insurance limits. They may not supervise youth in their own home and their supervision of youth is not reimbursed by Maple Star Oregon. Alternative Caregivers are helpful in emergency situations when Family Care Providers may not be able to respond to youth crisis in a timely manner. Please use this information in answering the question below.******

Please fill out the chart below with people who would be able to act as an alternative caregiver during times you may be unavailable:

Name	DOB	Gender	Contact Information (Phone Number Address)	Times they are available	Relationship to Applicant #1

Transportation

Do you have a vehicle, auto insurance, a reasonably clean driving record, and valid Oregon Driver's License? ☐Yes ☐No

If no, what is your mode of transportation?_____

Is there any reason you would not be able to provide routine or scheduled transportation? ☐Yes ☐No

Is there any reason you would not be able to provide short notice or unexpected transportation? ☐Yes ☐No

How far or long are you willing to transport youth for routine services (doctor appointments, family visits, school, therapy, etc.)?

Other

Is there any additional information we should know about you?

Is there any additional information you need from Maple Star Oregon?

References

Identify four personal references who can comment on your demeanor and ability to care for high-needs youth. ***Each reference must have known you for at least two years and only one reference may be closely related to you.***

1. Name:	2. Name:
Address:	Address:
Phone:	Phone:
How do they know you?	How do they know you?
3. Name:	4. Name:
Address:	Address:
Phone:	Phone:
How do they know you?	How do they know you?

MAPLE STAR OREGON PRE-CERTIFICATION GUIDELINES

By checking each box below, I acknowledge I have read the following Pre-Screening Guidelines:

☐ I have a source of income to cover my own expenses.
☐ I have Internet access and an email account (other than your cell phone).
☐ In a two-parent household I have no more than four children residing in my home.
☐ In a one-parent household I have no more than three children residing in my home.
☐ I have no more than two children under the age of two years old residing in my home.
☐ I am willing to maintain my home environment in compliance with Maple Star Oregon's Home Health and Safety Checklist.
☐ I am willing to ensure that my auto insurance coverage limits will be at least: $100,000 per person and $300,000 per accident of injury liability or $300,000 combined liability; and $50,000 property damage.
☐ I am willing to ensure that my Homeowners or Renters insurance coverage limits will be at least: $100,000 per occurrence
☐ All applicants are willing to provide an accurate resume documenting the last five years of work history.
☐ All household members 16 years of age and older are willing to complete 301cp Background check forms and provide a completed fingerprint card.

Please consider the following questions:

☐ Have you discussed with your own children and other family members how providing foster care would affect them?
☐ Will you be able to complete the annual training requirements? (30 hours a year for primary applicant, 24 hours a year for support applicant)
☐ Will you be able to commit to regularly attending meetings, engaging in Family Care Provider Support services, and returning phone calls?

Please attach the following documents:

☐ Copy of OR DL or ID for all members in household 16 and older. If a household member does not have OR DL or ID, please provide a copy of a photo ID.
☐ Copy of Social Security Card for all applicants.

AUTHORIZATION AND AGREEMENT

1. I certify that the facts and information set forth in this application are true and complete to the best of my knowledge. I understand that any falsification, misrepresentation, or omission of fact in this application or any other required documents, as well as any misleading statements or omissions, may be cause for denial or immediate termination of foster home certification, regardless of how or when discovered.
2. I understand that Maple Star Oregon reserves the exclusive right to certify or not certify an applicant. All certification decisions are based upon Maple Star Oregon's needs and interests, the best interests of the children we serve, as well as applicants' qualifications, knowledge, skills, abilities and experience relevant to foster parenting.
3. I understand that financial reimbursement for care of foster children in my home will only be provided according to the signed Family Care Provider Contract and additional exhibits with Maple Star Oregon.
4. I authorize the investigation of all matters which Maple Star Oregon deems relevant to my qualifications, including all statements in this application. I release from liability any person, employer or other named or unnamed informant supplying such information, and release Maple Star Oregon from all liability that may result from making the investigation. This includes any reference checks or criminal background checks prior to or following foster home certification.
5. I affirm and acknowledge that I am not an Ineligible Person as defined in the Criminal Convictions and Exclusions Policy.
6. As an applicant/Family Care Provider I shall participate in certification, re-certifications and evaluations, and in the ongoing monitoring of my home, and shall give information required to verify compliance with all the rules, including change of address and number of persons in the household
7. I have read, understand, and accept the above statements.

Applicant #1 (Print Name)_____ Signature_____ Date_____

Applicant #2 (Print Name)_____ Signature_____ Date_____

Note: This application expires within 180 days of date signed by applicant.

To be completed by Certification/Designee:

Date received: _____ Date reviewed: _____ Certifier/Designee Signature: _____