



Fresh Start Family Services

TREATMENT FOSTER PARENT APPLICATION

NAME: _____
 (APPLICANT FOR PRIMARY FOSTER PARENT-Applicant #1)

DATE OF BIRTH: _____

PHONE #: _____

S.S.#: _____

RELIGION: _____

DRIVER'S LICENSE #: _____

OCCUPATION: _____

WEEKLY GROSS INCOME: _____

EMPLOYER: _____

WORK PHONE: _____

NAME: _____
 (APPLICANT FOR SUPPORTIVE FOSTER PARENT-Applicant #2)

DATE OF BIRTH: _____

PHONE #: _____

S.S.#: _____

RELIGION: _____

DRIVER'S LICENSE #: _____

OCCUPATION: _____

WEEKLY GROSS INCOME: _____

EMPLOYER: _____

WORK PHONE: _____

RELATIONSHIP TO APPLICANT #1: _____

LENGTH OF RELATIONSHIP: _____

OTHER SOURCE (S) OF INCOME (ex. second job, at home business, alimony, child support, disability, AFDC, etc.):

TOTAL INCOME (Weekly Gross - primary employment and other income): _____

ADDRESS: Residence _____ Mailing _____

OTHER HOUSEHOLD MEMBERS:

NAME	DOB	SEX	RELATIONSHIP

CHILDREN NOT LIVING IN THE HOME:

NAME	DOB	RESIDENCE/SITUATION

SCHOOLS: (Which school system serves your town?)

Elementary _____
 Middle School _____
 High School _____

Transportation (Circle One): Walk Bus Car
 Transportation (Circle One): Walk Bus Car
 Transportation (Circle One): Walk Bus Car

DIRECTIONS TO YOUR HOME: (Be specific and as detailed as possible. Start from a known point such as a post office, intersection of number routes, or other reference point that is easy to find.)

PERSONAL HISTORY: (Explain yes answers on separate sheet of paper.)

- Have you or any person residing in your household (indicate who) ever: Yes No
- Received a summons for any traffic violations in the past 3 years? Yes No
- Had a driver's license revoked or placed on suspension? Yes No
- Been arrested or convicted of any crime other than a traffic violation? Yes No
- Been arrested or convicted of any sexual crimes of any nature? Yes No
- Been arrested or convicted for operating a motor vehicle under the Influence? Yes No
- Been involved in mental health counseling, admitted to a mental health facility or hospitalized for a psychiatric/emotional disorder? Yes No
- Been involved in substance abuse counseling or treatment? Yes No
- Been investigated by Child Protective Services? Yes No
- Had a child removed from your care or custody as a result of allegations of abuse, neglect, or abandonment? Yes No
- Lived outside of the State of Wisconsin as an adult? Yes No
 - Who _____ What State (s) _____ Years? _____
 - Who _____ What State (s) _____ Years? _____

*****APPLICANT(S) MUST PROVIDE A COPY OF THE POLICE AND COURT REPORT WITH THIS APPLICATION DETAILING INCIDENT(S)*****

MARITAL HISTORY:

Has **applicant #1** been married before? _____
 If yes, date(s) of marriage(s): _____

Has **applicant #2** been married before? _____
 If yes, date(s) of marriage(s): _____

Place of marriage(s): _____

Place of marriage(s): _____

Name(s) of former spouse(s): _____

Name(s) of former spouse(s): _____

Date(s) of death(s)/divorce(s): _____

Date(s) of death(s)/divorce(s): _____

MEDICAL HISTORY: (Explain yes answers on separate sheet of paper).

- Have you or any person residing in your household (indicate who) ever had:

- Alcoholism or Substance Abuse Yes No
 - Communicable disease (please specify) Yes No
 - Diabetes Yes No
 - High Blood pressure Yes No
 - Heart disease Yes No
 - Mental or Emotional Illness Yes No
 - Would you be willing to sign a release for FSFS to obtain medical records if necessary? Yes No
 - Please list any prescription medications currently being used in your household, who takes them, and their purpose.
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LICENSING/CONTRACTING INFORMATION:

- Would you be willing to change your home in order to meet licensing regulations? Yes No
- Is your home currently a licensed foster home through DHFS/BRL? Yes No
- If no, have you ever been? Yes No
- If yes, please enclose a photocopy of your most recent license with this application. Yes No
 - Have you ever applied to another foster care program? Yes No
 - If yes, who? _____
 - Are you currently affiliated with another foster care program? Yes No
 - If yes, who? _____
- Have you ever had a foster care license revoked or placed on suspension? Yes No
- Would you be willing to learn new parenting techniques? Yes No

FOSTER CARE INTERESTS: (Indicate what type of foster care you are interested in providing.)

<u>TYPE OF CARE</u>			<u>AGE GROUP</u>			<u>SEX(Male/Female/Either)</u>		
Emergency/Crisis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	0 - 5	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> E
Respite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	6 - 9	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> E
Long-Term	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10 - 13	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> E
			14 - 17	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> E
			18 - 20	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> E

FOSTER CARE CHALLENGES:

Indicate any special needs you **would (YES)** or specifically **would not (NO)** like to work with as a Foster Parent:

Abusive to animals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ADD/ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical disabilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical/emotional abuse victim	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Behavior problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor bladder/bowel control	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmental delays	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Racial or ethnic differences	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug/alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexual abuse victim	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexual acting out	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fire setting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sibling group	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Speech/communication impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Visual impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REFERENCES: (Give the names, addresses, and phone numbers of three people, other than relatives, who can provide information regarding your parenting and/or child care giving experience and abilities. Additional references may be requested.)

- 1) _____
(Name) (Mailing Address) (Phone)
- 2) _____
(Name) (Mailing Address) (Phone)
- 3) _____
(Name) (Mailing Address) (Phone)

I acknowledge that all statements provided in this application are, to the best of my knowledge correct and that any misrepresentation or false statements will be a basis for denial in Fresh Start Family Services (FSFS) Treatment Foster Care Program. As a prospective Treatment Foster Parent applying to FSFS, I realize that the Department of Health and Family Services (DHFS) is the State Licensing Agency and I must complete the application, background/reference checks, and home study/training process required by both FSFS and DHFS. I understand that, regardless of the number of interviews or the amount of training I may have already attended, FSFS may decide not to contract with me for Treatment Foster Parenting. However, if approved by FSFS to become a Treatment Foster Home, placement is not guaranteed. I further understand that these decisions are made based on the needs of the children placed in FSFS.

By signing this application I agree to allow FSFS to randomly check my background checks with the department of justice, local police, FBI and Sheriff's departments.

Additional documentation may be required as this application is processed.

APPLICANT #1 SIGNATURE

DATE

APPLICANT #2 SIGNATURE

DATE

Please return TREATMENT FOSTER PARENT APPLICATION and RELEASES OF INFORMATION to:

**Fresh Start Family Services
7101 West Capitol Drive
Milwaukee, WI 53216
Attention: Foster Care Licensing Dept.**



Fresh Start Family Services

FOSTER PARENT APPLICANT

RELEASE OF INFORMATION

I, _____ ,
agree that the Fresh Start Family Services Foster Care Licensing Division may share otherwise confidential information about me and/or my family relevant to the Foster Home License.

I understand that any and all such information will remain confidential and be used solely for the purpose of processing my Foster Parent application. This release will remain in effect until year from the completion of the application process.

PLEASE PRINT ALL INFORMATION:

Full Name: _____
(including any name used previously such as maiden name, etc.)

Current Address:
Street _____ City _____ County _____

Social Security Number: _____ Date of Birth: _____

Applicant Signature Date

PLEASE PRINT ALL INFORMATION:

Full Name: _____
(including any name used previously such as maiden name, etc.)

Current Address:
Street _____ City _____ County _____

Social Security Number: _____ Date of Birth: _____

Applicant Signature Date

Witness Signature Date