



Foster Parent Application Checklist

Enclosed in this packet, you will find the Arrow forms that need to be completed for your file. In addition to the Arrow forms, you will also need to provide Arrow with supplementary documents included in the checklist below. The checklist includes the Arrow forms needed for the complete application packet, supplementary documentation needed for you, required trainings, and documents/tasks you will complete after licensure. These documents should be sent to your Family Home Developer (FHD), _____, at _____@arrow.org.
(Name) (Email)

Application Process

Items that are time-sensitive and should be turned in FIRST:

- Foster/Adopt Parent Application, Arrow will send out Reference letters.
 - Reference from all children 12+ living outside of the home, information sent to Arrow
- 2 non-relative references (e.g., neighbors, clergy, school personnel, community members, friends), information sent to Arrow
 - 1 reference from a family member (excluding those living in the home and adult children)
- Criminal Background Check for all household members 14+ (including DPS, FBI, and Central Registry)
- Out-of-State Background Check, if resided outside of Texas within past 5 years
- Fingerprinting for all household members 14+ **Please note your fingerprint request will be closed if you are not fingerprinted within 30 days of email from fingerprinting agency*
- Copies of Driver's License and Social Security Card
- Consent to Release Information, if applicable

Arrow Forms

- Floor Plan/Evacuation Route
- Recreational Plan
- Pet Inventory and vaccination records
- Weapons Inventory
- Disaster and Emergency Plan
- Photos of home (4 photos of your home; front, sides, and back. All outside areas of your home showing buildings, driveways, fences, storage areas, gardens, recreational areas, pools, ponds, or other bodies of water, if applicable)
- Family photo
- Adult Medical Form (Health Assessment), one for each parent **Needs to be completed and signed by healthcare provider*
- Budget Form
- Autobiography, for each parent
- Care Provider Checklist, if applicable for office

Supplementary Documentation

- Proof of income for the past 60 days (pay stubs are preferred, but office may accept income verification letter from bank, etc.)
- Verification of financial status (**EITHER** 2 consecutive itemized bank statements **OR** the previous year's tax return)
- Verification of highest level of education (GED, diploma, transcripts, etc.)
- Copy of Marriage License/Divorce Decree/Death Certificate
- Proof of auto insurance Proof of current auto registration
- DPS Driving Record (Type AR), one for each parent. Order by going to: <http://www.txdps.state.tx.us/DriverLicense/driverrecords.htm> or type in www.txdps.state.tx.us and click on "Services" then "Drivers License/ID" then "Driver Record Request."
- Disclosure of Family Violence Form

- Agency run check of calls made to law enforcement from the home in the past 24 months
- Health Inspection (completed by county or Arrow staff)
- Fire Inspection (completed by county or Arrow staff) **PMN homes are required to have fire inspection by county*
- Gas Pressure Test, if applicable

Required Trainings

- Pre-Service Training 1-7 (in-person with Arrow)
- Adoption Training (in-person or online via webinar)
- BCMT (in-person with Arrow)
- Human Trafficking 101 (Restoration Foster Care only)
- Medication Administration (in-person with Arrow)
- PMN Treatment Training (PMN families only)
- TBRI Training (Treatment Foster Care and Restoration Foster Care only)
- CPR and First Aid (adult, child, and infant) **Online certifications are not accepted*
- Cultural Competency Training (Arrow online)
- Emergency/Disaster Planning (Arrow online)
- Transportation Training, if applicable (Arrow online)
- Normalcy Training for Foster Parents (online, DFPS training)
- Medical Consent Training for Non-DFPS Employees (online, DFPS training)
- Psychotropic Medication (online, DFPS training)
- Recognizing and Reporting Child Sexual Abuse (online, DFPS training)
- Recognizing and Reporting Suspected Abuse and Neglect of a Child: A Guide for Professionals (online, DFPS training)
- Trauma Informed Care Training (DFPS online)

Items Completed at/after Licensure, if applicable

- TB test for all household members age 12 months or older (completed within 30 days of licensure)
- Signed documents related to licensing:
 - Foster Parent Agreement
 - Foster Parent Agreement Addendum
 - Confidentiality Statement
 - Discipline Agreement
 - Acknowledgement Agreement
- Foster Parent and CPA Rights and Responsibilities



Foster/Adopt Parent Application

(Please type or print legibly)

Office Use Only	
Office:	License/Cert. #:
Date App. Started:	
Date: App. Completed:	
Date Certified:	

Family Name:

(ex: Smith, John & Mary)

Program Interested in: Foster Foster to Adopt Adopt Only Kinship/Fictive Kin Respite
 Treatment Foster Care Restoration Foster Care PMN

How did you hear about Arrow?

If Kinship, please provide child's worker information:

Case Worker Name:			
Email Address:		Cell Phone:	()
Ad Litem Name:			
Email Address:		Cell Phone:	()
CASA Name:			
Email Address:		Cell Phone:	()

ADDRESS INFORMATION

Current Address _____ **Home Phone:** ()

Type of Residence: Private Res. Apartment Condo Rental Home Other:

Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____ **Years at address:** _____

Mailing address *(complete only if different than Current Address)*

Type of Address: Post Office Box Private Res. Apartment Condo Rental Home Other:

Address: _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____ **Years at address:** _____

FAMILY STRUCTURE

Marital Status: Married Single *(Never married)* Co-Habitation Divorced Widowed

of Dependents: _____ **Family Size:** _____ **Total Family Income:** \$ _____
 Yrly. Mnthly. Bi-Wkly. Wkly. Daily Hourly

APPLICANT/S PERSONAL INFORMATION

(If you are married or Co-Habiting, both of you must apply below)

Applicant #1	
Role in Family:	<input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other:
Last Name:	
Salutation: <i>(if applicable)</i>	
Maiden Name: <i>(if applicable)</i>	
First Name:	
Middle Name:	
Date of Birth:	
Other Names Used:	
Place of Birth:	
Citizenship (country):	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race/Ethnicity:	
Height:	Weight:
Hair Color:	Eye Color:
Tribal Affiliation:	
Language(s):	
Social Sec. No:	
State Driver's License #:	#:

Applicant #2	
Role in Family:	<input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other:
Last Name:	
Salutation: <i>(if applicable)</i>	
Maiden Name: <i>(if applicable)</i>	
First Name:	
Middle Name:	
Date of Birth:	
Other Names Used:	
Place of Birth:	
Citizenship (country):	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race/Ethnicity:	
Height:	Weight:
Hair Color:	Eye Color:
Tribal Affiliation:	
Language(s):	
Social Sec. No:	
State Driver's License #:	#:

or Other State ID #:	Type:	
Cell Phone #:		
Email Address:		
<u>Religious Affiliation</u>		
Religion:		
Church name attending: <i>(if applicable)</i>		
How often attend services?		
<u>Academic History</u>		
Highest Education:	<input type="checkbox"/> Grade School	<input type="checkbox"/> Junior High
<input type="checkbox"/> Senior High (not grad.)	<input type="checkbox"/> High School Graduate/GED	
<input type="checkbox"/> College (not grad.)	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
<input type="checkbox"/> Masters	<input type="checkbox"/> Doctorate	
High School:		
College:	Degree type:	Years:
College:	Degree type:	Years:
College:	Degree type:	Years:
Business/Vocational School(s):	Years:	
Certificates:		
Professional Licenses or Certifications:		
Special Training or Expertise: _____		
<u>Employment History</u>		
<u>Present Employer</u>		
Employer Name:		
Address:		
City/State/Zip:		
Work Phone #:		
Position or Title:		
Date of Employment:		
Length of Employment:		
Salary or Wage:	\$	
Work hours:		
Supervisor's Name:		
<i>(If employed by present employer is less than three years, please list previous employment below)</i>		
<u>Previous Employer</u>		
Previous Employer Name:		
Address:		
City/State/Zip:		
Work Phone #:		
Position or Title:		
Date of Employment:	Start:	End:
Length of Employment:		
Salary or Wage:	\$	
Reason for leaving:		
Supervisor's Name:		

or Other State ID #:	Type:	
Cell Phone #:		
Email Address:		
<u>Religious Affiliation</u>		
Religion:		
Church name attending: <i>(if applicable)</i>		
How often attend services?		
<u>Academic History</u>		
Highest Education:	<input type="checkbox"/> Grade School	<input type="checkbox"/> Junior High
<input type="checkbox"/> Senior High (not grad.)	<input type="checkbox"/> High School Graduate/GED	
<input type="checkbox"/> College (not grad.)	<input type="checkbox"/> Associate Degree	<input type="checkbox"/> Bachelor Degree
<input type="checkbox"/> Masters	<input type="checkbox"/> Doctorate	
High School:		
College:	Degree type:	Years:
College:	Degree type:	Years:
College:	Degree type:	Years:
Business/Vocational School(s):	Years:	
Certificates:		
Professional Licenses or Certifications:		
Special Training or Expertise: _____		
<u>Employment History</u>		
<u>Present Employer</u>		
Employer Name:		
Address:		
City/State/Zip:		
Work Phone #:		
Position or Title:		
Date of Employment:		
Length of Employment:		
Salary or Wage:	\$	
Work hours:		
Supervisor's Name:		
<i>(If employed by present employer is less than three years, please list previous employment below)</i>		
<u>Previous Employer</u>		
Previous Employer Name:		
Address:		
City/State/Zip:		
Work Phone #:		
Position or Title:		
Date of Employment:	Start:	End:
Length of Employment:		
Salary or Wage:	\$	
Reason for leaving:		
Supervisor's Name:		

APPLICANT #1 RESIDENTIAL HISTORY (Please list all places of residence during previous 10 years if different from current address)

Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:

APPLICANT #2 RESIDENTIAL HISTORY (Please list all places of residence during previous 10 years if different from current address)

Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:

OTHER HOUSEHOLD MEMBERS RESIDENTIAL HISTORY

(Please list all places of residence during previous 10 years if different from current address)

Full Name: _____				
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Full Name (if different from the name listed above): _____				
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Full Name (if different from the name listed above): _____				
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Full Name (if different from the name listed above): _____				
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:
Full Name (if different from the name listed above): _____				
Address: _____				
City:	State:	Zip:	County:	From Date- To Date:

(Please use an additional page to complete this section, if necessary)

Citizenship		
U.S. Citizen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Legal Resident:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Military Information <input type="checkbox"/> <i>Never been in the Military</i>		
Branch(es) of Service: _____		
Date of Service:	Start: _____	End: _____
Discharged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Discharge: _____		
<i>(attached DD214)</i>		
Health Information		
Describe your current health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Disabled		
List any handicaps, serious illnesses, operations, or chronic conditions within the past ten years & the date/s it covered: _____		
Date of Last Physical: _____		
Date of Latest TB Test: _____		
<i>(attach copy of TB results – if apply)</i>		
Marital History		
Current Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> In relationship		
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Date of current marriage: _____		
Have both you and your spouse discussed foster parenting, and you both are supportive and similarly motivated to foster parenting? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Previous Marriages <i>(complete only if applies)</i>		
Name of Previous Spouse: _____		
Date of Marriage: _____		
From: _____ To: _____		
How ended: <input type="checkbox"/> Death <input type="checkbox"/> Divorce		
County, State: _____		
<i>(attach copy of Divorce or Death certificate)</i>		
Name of Previous Spouse: _____		
Date of Marriage: _____		
From: _____ To: _____		
How ended: <input type="checkbox"/> Death <input type="checkbox"/> Divorce		
County, State of divorce: _____		
<i>(attach copy of Divorce or Death certificate)</i>		
Name of Previous Spouse: _____		
Date of Marriage: _____		
From: _____ To: _____		
How ended: <input type="checkbox"/> Death <input type="checkbox"/> Divorce		
County, State of divorce: _____		
<i>(attach copy of Divorce or Death certificate)</i>		

Citizenship		
U.S. Citizen:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Legal Resident:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Military Information <input type="checkbox"/> <i>Never been in the Military</i>		
Branch(es) of Service: _____		
Date of Service:	Start: _____	End: _____
Discharged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of Discharge: _____		
<i>(attached DD214)</i>		
Health Information		
Describe your current health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Disabled		
List any handicaps, serious illnesses, operations, or chronic conditions within the past ten years & the date/s it covered: _____		
Last Physical: _____		
Latest TB Test: _____		
<i>(attach copy of TB results – if apply)</i>		
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Previous Marriages <i>(complete only if applies)</i>		
Name of Previous Spouse: _____		
Date of Marriage: _____		
From: _____ To: _____		
How ended: <input type="checkbox"/> Death <input type="checkbox"/> Divorce		
County, State : _____		
<i>(attach copy of Divorce or Death certificate)</i>		
Name of Previous Spouse: _____		
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From: _____ To: _____		
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County, State of divorce: _____		
<i>(attach copy of Divorce or Death certificate)</i>		

(Please use additional pages if necessary)

PREVIOUS CHILD CARE EXPERIENCE

Previous Child Care Experience <i>(do not include foster care)</i> <i>(Include church, community, volunteer, family, etc.)</i>

Previous Child Care Experience <i>(do not include foster care)</i> <i>(Include church, community, volunteer, family, etc.)</i>

APPLICANT/S BACKGROUND QUESTIONNAIRE

Applicant #1

Applicant #2

Personal Background Information

- Yes No Have you ever been involved in, either as an aggressor or victim, an act of assault, child battering, child abuse, child molestation or child neglect?
- Yes No Have you ever been convicted or are you currently charged with a felony or misdemeanor classified as an offense against a person, family, public indecency, or any violation of the Controlled Substance Act?
- Yes No Have you ever been charged with a felony?
- Yes No Are you now receiving or have you ever received treatment for chemical dependency?
- Yes No Do you object to a criminal records check?
- Yes No Have you ever been hospitalized for an emotional or mental illness?
- Yes No Are you now receiving or have you ever received psychiatric treatment?
- Yes No Do you have any significant acute or chronic medical condition that could affect your ability to foster parent children?
- Yes No Have any of your children ever been placed in foster care, a treatment facility for emotional or mental disturbance, or been committed to a state correctional facility?
- Yes No Do you expect any change in marital status, employment, family size or place of residence within the next year?

Explain, if "Yes" to any answer:

Criminal Record Check: *In accordance with Arrow Child & Family Ministries policy and State Human Resources licensing standards, a criminal record background check is conducted on all foster parent applicants, and any person/s living in the household 14 year or older (ages may vary per State), to determine whether any offenses have been committed which might adversely affect foster parenting eligibility.*

CURRENT FOSTER /ADOPT PREFERENCES

Please complete the questions below to help us with matching children to your family.

Preferences

- Gender:** Male Female Both
- African Am. Hispanic Caucasian
- Race:** Am. Indian Mixed Any, no Preference
- Note:**

Age(s): _____

Number of children: _____

List behavior or problems unacceptable to you in a child:

Other information helpful in matching children to your family:

Personal Background Information

- Yes No Have you ever been involved in, either as an aggressor or victim, an act of assault, child battering, child abuse, child molestation or child neglect?
- Yes No Have you ever been convicted or are you currently charged with a felony or misdemeanor classified as an offense against a person, family, public indecency, or any violation of the Controlled Substance Act?
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- Yes No Do you object to a criminal records check?
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- Note:**

Age(s): _____

Number of children: _____

List behavior or problems unacceptable to you in a child:

Other information helpful in matching children to your family:

Doctor/Dentist Information for Foster Children

Please list the name, complete address, and phone number of the doctor and dentist who will be seeing the foster child(ren) in your home.
 *In Texas, the doctor and dentist must accept STAR Health.

Physician: _____				
Address: _____				
City: _____	State: _____	Zip: _____	County: _____	Phone: _____
Dentist: _____				
Address: _____				
City: _____	State: _____	Zip: _____	County: _____	Phone: _____

APPLICANT/S DECLARATION OF INFORMATION

<p align="center"><u>Applicant #1</u></p> <p>I hereby declare the information I have provided on this foster/adopt parent application to be true and complete to the best of my knowledge. I understand that any misstatement or omission of fact(s) on this application could be considered cause for disapproval as a foster/adopt parent.</p> <p>I authorize Arrow Child & Family Ministries to obtain any information that would assist in the evaluation of my application to participate in the foster/adopt care program.</p> <p>As part of Arrow Child & Family Ministries matching process, authorized Arrow personnel upon request may elicit additional personal information from the applicant.</p>	<p align="center"><u>Applicant #2</u></p> <p>I hereby declare the information I have provided on this foster/adopt parent application to be true and complete to the best of my knowledge. I understand that any misstatement or omission of fact(s) on this application could be considered cause for disapproval as a foster/adopt parent.</p> <p>I authorize Arrow Child & Family Ministries to obtain any information that would assist in the evaluation of my application to participate in the foster/adopt care program.</p> <p>As part of Arrow Child & Family Ministries matching process, authorized Arrow personnel upon request may elicit additional personal information from the applicant.</p>				
<table style="width:100%; border: none;"> <tr> <td style="border: none; width: 80%;">Signature of Applicant #1</td> <td style="border: none; width: 20%;">Date</td> </tr> </table>	Signature of Applicant #1	Date	<table style="width:100%; border: none;"> <tr> <td style="border: none; width: 80%;">Signature of Applicant #2</td> <td style="border: none; width: 20%;">Date</td> </tr> </table>	Signature of Applicant #2	Date
Signature of Applicant #1	Date				
Signature of Applicant #2	Date				

HOUSEHOLD MEMBERS INFORMATION

(List anyone living in the home at any time during the year)

Provide the following information on every person living in your household, other than Applicant #1 & #2

NAME	Last:	First:	Middle:
# of months you live in the home?	Relationship	Related to:	Age
<input type="checkbox"/> All Yr. <input type="checkbox"/> 6+ mo. yr <input type="checkbox"/> - 6 mo. yr	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	DOB
			Sex
			SocSecNo.
			Email (if have one)
			Birth Place:
Any serious illness, handicap, chronic problem, or nervous condition/s: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe treatment and/or counseling, give dates)			

NAME	Last:	First:	Middle:
# of months you live in the home?	Relationship	Related to:	Age
<input type="checkbox"/> All Yr. <input type="checkbox"/> 6+ mo. yr <input type="checkbox"/> - 6 mo. yr	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	DOB
			Sex
			SocSecNo.
			Email (if have one)
			Birth Place:
Any serious illness, handicap, chronic problem, or nervous condition/s: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe treatment and/or counseling, give dates)			

NAME	Last:	First:	Middle:
# of months you live in the home?	Relationship	Related to:	Age
<input type="checkbox"/> All Yr. <input type="checkbox"/> 6+ mo. yr <input type="checkbox"/> - 6 mo. yr	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	DOB
			Sex
			SocSecNo.
			Email (if have one)
			Birth Place:
Any serious illness, handicap, chronic problem, or nervous condition/s: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe treatment and/or counseling, give dates)			

NAME	Last:	First:	Middle:
# of months you live in the home?	Relationship	Related to:	Age
<input type="checkbox"/> All Yr. <input type="checkbox"/> 6+ mo. yr <input type="checkbox"/> - 6 mo. yr	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	DOB
			Sex
			SocSecNo.
			Email (if have one)
			Birth Place:
Any serious illness, handicap, chronic problem, or nervous condition/s: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe treatment and/or counseling, give dates)			

NAME	Last:	First:	Middle:
# of months you live in the home?	Relationship	Related to:	Age
<input type="checkbox"/> All Yr. <input type="checkbox"/> 6+ mo. yr <input type="checkbox"/> - 6 mo. yr	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	DOB
			Sex
			SocSecNo.
			Email (if have one)
			Birth Place:
Any serious illness, handicap, chronic problem, or nervous condition/s: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe treatment and/or counseling, give dates)			

(Please use an additional page if there are more Household Members in your home than spaces on this form)

OTHER CHILDREN LIVING OUTSIDE OF HOUSEHOLD INFORMATION

Provide names of any children you or your spouse have that live outside of your household. Include grown children.

(NOTE: Arrow is required to obtain references from all of your children living outside of your household.)

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

NAME	Last:			First:			Middle:		
Relationship	Related to:		Sex	DOB	Age	Street Address City/State/Zip			Phone No. & Email
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other:	<input type="checkbox"/> Both <input type="checkbox"/> Dad <input type="checkbox"/> Mom <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female							Phone #: _____ Email: _____

Yes No **Have you discussed foster/adopt parenting with your family members?**
 Yes No **Are they supportive of your decision?**

(Please use an additional page if there are more Household Members in your home than spaces on this form)

PERSONAL REFERENCES

Please list four persons or couples, not related to you, who have known you well enough for at least two years. These references must be able to accurately inform us of your moral character as well as life style. Local references are preferred, but if none are available out of town references will be accepted. Please try to vary the nature of your references, including those from spiritual, business, or employment relationships, as well as social relationships. Additionally, please list one relative that can provide a reference for you. Please provide the information requested below:

<u>NAME</u>	Last:	First:	Middle:
Relationship	Street Address City/State/Zip	Phone Numbers	# of Years Known and Email
<input type="checkbox"/> Friend <input type="checkbox"/> Spiritual <input type="checkbox"/> Other:	_____	Home: _____ Cell: _____ Work: _____	# of Years Known: _____ Email: _____

<u>NAME</u>	Last:	First:	Middle:
Relationship	Street Address City/State/Zip	Phone Numbers	# of Years Known and Email
<input type="checkbox"/> Friend <input type="checkbox"/> Spiritual <input type="checkbox"/> Other:	_____	Home: _____ Cell: _____ Work: _____	# of Years Known: _____ Email: _____

<u>NAME</u>	Last:	First:	Middle:
Relationship	Street Address City/State/Zip	Phone Numbers	# of Years Known and Email
<input type="checkbox"/> Friend <input type="checkbox"/> Spiritual <input type="checkbox"/> Other:	_____	Home: _____ Cell: _____ Work: _____	# of Years Known: _____ Email: _____

<u>NAME</u>	Last:	First:	Middle:
Relationship	Street Address City/State/Zip	Phone Numbers	# of Years Known and Email
<input type="checkbox"/> Friend <input type="checkbox"/> Spiritual <input type="checkbox"/> Other:	_____	Home: _____ Cell: _____ Work: _____	# of Years Known: _____ Email: _____

NEAREST LIVING RELATIVE – NOT LIVING WITH YOU

<u>NAME</u>	Last:	First:	Middle:
Relationship	Street Address City/State/Zip	Phone Numbers	# of Years Known and Email
	_____	Home: _____ Cell: _____ Work: _____	# of Years Known: _____ Email: _____

Note: A reference form will be sent to each person listed to complete and return to our office

HOME & COMMUNITY

Type of residence: Single Family Dwelling Duplex Triplex Apartment Mobile Home Single Story Home Multi-level Home
 Home owned/Purchasing Renting Square footage: _____ Length of time in residence: _____ yrs. mo.
Applicant(s) planning on moving? Yes No If yes, when? _____ Year built _____
of Bedrooms: _____ | **Check any of the amenities listed below that you may have at you residence:**
of Bathrooms: _____ | Pool Hot Tub Fireplace Fenced yard Covered Patio Woodstove Stairs
 Yes No Any other bodies of water located on property (pond/creek/lake)? If yes, explain: _____

Yes No Are they fenced? If yes, explain: _____

Special highlights of the home or property:

Briefly describe the neighborhood (class of families, children, parks, shopping areas, doctor offices, etc.): _____

Local Schools: *(School Name, City, State)*

Elementary

Middle/Jr. High

High School

Hospital/s: *(nearest your residence)*

Yes No Alcoholic beverages in home? If yes, are they stored in an unlocked refrigerator or out in the open? Yes No
 Yes No Tobacco Products – does anyone in your home or on your property use tobacco? If yes, Name:
 Yes No Medical Marijuana – does anyone in your home or on your property use medical marijuana? If yes, Name:

APPLICANT(S) VEHICLES

***Please attach a copy of the following for all drivers:** Driver's License Insurance cards for each vehicle used to transport kids
 State Registration

VEHICLE #1

Drivers covered by insurance for this car: Applicant #1 Applicant #2 Other driver/s:
 Yes No Will children be transported in this car? Number of seats available for children *(excluding front seat)*:

Make:	Model:	Year:
Insurance carrier:	Policy Period:	Starts: Ends:
Date State Inspection Expires: <i>(NA to TX or CA applicants)</i>	Date State Registration Expires:	
Condition of car: Exterior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Interior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Tires: <input type="checkbox"/> Good <input type="checkbox"/> Worn <input type="checkbox"/> Poor Dents: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other condition issues:	

VEHICLE #2

Drivers covered by insurance for this car: Applicant #1 Applicant #2 Other driver/s:
 Yes No Will children be transported in this car? Number of seats available for children *(excluding front seat)*:

Make:	Model:	Year:
Insurance carrier:	Policy Period:	Starts: Ends:
Date State Inspection Expires: <i>(NA to TX or CA applicants)</i>	Date State Registration Expires:	
Condition of car: Exterior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Interior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Tires: <input type="checkbox"/> Good <input type="checkbox"/> Worn <input type="checkbox"/> Poor Dents: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other condition issues:	

VEHICLE #3

Drivers covered by insurance for this car: Applicant #1 Applicant #2 Other driver/s:
 Yes No Will children be transported in this car? Number of seats available for children *(excluding front seat)*:

Make:	Model:	Year:
Insurance carrier:	Policy Period:	Starts: Ends:
Date State Inspection Expires: <i>(NA to TX or CA applicants)</i>	Date State Registration Expires:	
Condition of car: Exterior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Interior: <input type="checkbox"/> Good <input type="checkbox"/> Poor Tires: <input type="checkbox"/> Good <input type="checkbox"/> Worn <input type="checkbox"/> Poor Dents: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other condition issues:	



Consent for Release of Information

Please list all agencies or related service office with whom you have been involved as a foster or adoptive parent, applicant, or volunteer, either in or outside the State of Texas.

Agency Name: _____ Dates: _____
Address: _____
City, State, Zip: _____
Phone number: _____ Fax Number: _____

Agency Name: _____ Dates: _____
Address: _____
City, State, Zip: _____
Phone number: _____ Fax Number: _____

Agency Name: _____ Dates: _____
Address: City, _____
State, Zip: _____
Phone number: _____ Fax Number: _____

I (We) have not been involved with any agency or related service office as a foster/adoptive parent, applicant, volunteer, or in any other capacity.

I (We) understand the above agencies will be contacted for verification of my (our) statement(s) and herby authorize, as a condition of and in consideration of becoming a foster/adoptive parent with ARROW TREATMENT FOSTER CARE, the release of any information from the above agencies regarding my (our) character, past conduct, foster or adoptive experiences and other related matters.

Applicant 1 Signature

Date

Applicant 2 Signature

Date

Criminal Record Check

In accordance with Arrow Child & Family Ministries policy and Texas Department of Family & Protective Services licensing standards DPS, CPS & FBI background checks are required for any individual who resides in a foster/adoptive family's home and is age 14 and over, or anyone who will be providing care for a foster child. (FBI background checks require the individual to be fingerprinted, at a cost of approximately \$40 per person.) DPS & CPS background checks are also required for individuals who are frequent visitors to a foster/adoptive home. By signing below you are giving Arrow Child & Family Ministries permission to conduct these background checks, to determine whether any offenses have been committed which may adversely affect your contact with foster children.

****A form should be completed for each foster/adoptive parent applicant, as well as all household members age 14 and over, and turned in to Arrow staff (with a copy of the individual's Driver's License or State ID, if applicable) as soon as possible. The form must be filled out completely. Nothing should be left blank. If something does not apply to you, simply put "N/A".****

Social Security Number		Drivers License or State Issued ID Number <small>(Please submit a copy)</small>		State	ID Type (DL or ID Card)
First Name		Middle Name		Last Name	
Street Address		City		State	Zip
County	Telephone No. (A/C)		Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Email:		Relationship of person to requestor			
List all other cities in TX where there has been residency. If you lived outside TX in the previous 5 years you must also list the previous address(es) outside of TX, including the county:		<input type="checkbox"/> Adoptive Parent		<input type="checkbox"/> Nurse	<input type="checkbox"/> Babysitter
		<input type="checkbox"/> Foster Parent		<input type="checkbox"/> Other Staff	<input type="checkbox"/> Short Term Child Care Provider
		<input type="checkbox"/> Household Member		<input type="checkbox"/> Frequent Visitor	<input type="checkbox"/> Respite Provider
		<input type="checkbox"/> Other		_____	
Date Hired (if applicable):	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Race <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native		
Other names used (married, maiden, etc.) First Name		Middle Name		Last Name	

Signature

Date



Photos of Foster Family's Property

(Family Name)

Please provide three photos of your home. The front, side, and back. All outside areas of your home showing buildings, driveways, fences, storage areas, gardens, recreation areas, pools, ponds, or other bodies of water if applicable. You may submit photos by mail, email or drop off at the office. Contact your Family Home Developer if you have any questions.

FHD Name:

FHD Email:

FHD Phone:



Outdoor Recreation Plan

Do you have a swimming pool or hot tub?	<input type="checkbox"/> Yes, Above-ground <input type="checkbox"/> Yes, In-ground <input type="checkbox"/> No Pool
Is there a fence around the pool or hot tube (not including the backyard fence)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Is there a locking gate on the fence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Is the drain in good repair and only removable with tools?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What is the square footage of the pool?	
What is the square footage of the hot tub?	
Are both parents able to swim and carry out water rescue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does either parent have water safety or lifeguard certification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a trampoline? <i>*There may be state regulations regarding foster children and the use of trampolines</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there climbing equipment, swings, or slides on your property?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is the equipment in good condition and installed over grass, sand, or other soft material?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there other bodies of water on your property or adjacent to your property? Yes No

If yes, please explain: _____

If you have a pool and/or hot tub, please answer:

What are the rules when in use? : _____

What are the rules when not in use? _____

What are the safety precautions when not in use? _____

What life saving devices and how many of each do you have in the pool area? _____

If you have a trampoline, how will you ensure safety when children use the trampoline? _____

I understand that it is my responsibility to adhere to water safety and trampoline requirements at my residence. Water safety and trampoline rules may be found in Texas' Minimum Standards, <https://hhs.texas.gov/doing-business-hhs/provider-portals/protective-services-providers/child-care-licensing/minimum-standards>.

Applicant/Foster Parent Signature

Date

Applicant/Foster Parent Signature

Date



Budget Form

Applicant Name(s): _____

Income	Employment	Gross Monthly	Net Monthly
Applicant # 1			
Applicant # 2			
Other Sources of Income: <i>(Explain)</i>			
Total Income Per Month			

Attach 2 recent pay stubs or bank statements and/or W-2

Expenses	Monthly	Total Owed
Home Mortgage		
Rent		
Other Property (mortgage or rent)		
Vehicles		
Gasoline and Maintenance		
Utilities and Telephone		
Groceries		
Medical and Dental		
Clothing		
Recreation and Entertainment		
Life Insurance (Please indicate if deducted from payroll)		
Medical Insurance (please indicate if deducted from payroll)		
Auto Insurance		
Daycare		
Pet Expenses		
Legal Expenses		
Miscellaneous (<i>i.e. Church</i>) (<i>specify</i>)		
Charge Accounts (<i>specify</i>)		

Other Debts (<i>i.e. Student Loans</i>) (<i>specify</i>)		
Total Expenses		

Assets	Value	Comments
Home		
Other Property		
Vehicles		
Savings Account		
Retirement		
Other Savings/Assets (<i>specify</i>)		
Total Assets		

Total Monthly Net Income	Total Monthly Expenses	Total Assets

Please describe in as much detail as possible how you plan to cover financial emergencies?

INSURANCE

1. **Medical Coverage: Do you have medical insurance?** Yes No

Applicant # 1 Carrier: _____

Applicant # 2 Carrier: _____

Children's Carrier: _____

A. Will you be adding your adoptive child to your personal Medical Insurance? Yes No

What carrier will cover the new child (adoption only)?

B. Will Coverage extend to the child at the time of adoptive placement? Yes No

C. Will insurance cover pre-existing conditions? Yes No

If you answered NO to any of these questions, please explain the following:

How do you plan to cover medical expense?

Please explain your medical emergency plan in detail:

Foster/Adoptive placements may change the benefits you are currently receiving from the state. Have you checked how your benefits might change?

2. **Life Insurance Coverage: Do you have Life Insurance?** Yes No

Applicant # 1 Carrier: _____

Applicant # 2 Carrier: _____

Children's Carrier: _____

Applicant 1 Signature

Date

Applicant 2 Signature

Date



Pet Policy & Verification

(Foster Family)

Foster homes must keep Arrow informed of the pets that live in the home. This also includes letting the agency know if pets are no longer in the home for whatever reason.

The *Minimum State Standards* state: To protect the health of the children, animals must be vaccinated and treated as recommended by a licensed veterinarian. **Documentation of vaccinations and treatment must be on file in the agency home.** Additionally, any stray animals must be vaccinated or removed from your home or property.

Please list pets and dates of most recent rabies vaccinations. This is an annual requirement. **Non-compliances must be corrected and verified within 7 days**

<u>Name of Pet</u>	<u>Type of Pet</u>	<u>Date & Type of Vaccination</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This foster home does not have pets at this time. If the home were to add a pet, I will notify my Arrow office within 24-hours of this addition and obtain and/or provide proof of the vaccinations as soon as possible.

Applicant/Foster Parent Signature

Date



Weapons Inventory

(Foster Family)

Weapons and ammunition must be locked and stored away from foster children. Weapons and ammunition may be locked in same area if weapons have a trigger lock. Please refer to the foster parent handbook for the complete weapons policy.

List of Weapons	Describe Storage of Weapons	Describe Storage of Ammunition

There are no weapons of any kind nor any ammunition stored anywhere in my home or on my property.

This is a complete listing of all the weapons currently in my home/on my property. I understand that I should notify an Arrow Representative of any additional weapons acquired or stored on the premises of my home in the future. I also understand I must review the safety issue of weapons and conduct an inventory of weapons with any respite provider I use with foster children.

Applicant or Foster Parent Signature

Date



FAMILY VIOLENCE CALLS DISCLOSURE FORM

Purpose: Use this form to document law enforcement service calls involving family violence at the prospective foster parents' addresses.

Directions: To complete this form, the foster home applicant(s) must list each incident of law enforcement responding to a report of family violence at their place of residence in the 24 months preceding the application to become a foster home. Please include the location, the date, and a description of each incident. If law enforcement did not respond to any reports of family violence at the home, write NONE in the Description of Incident section.

This form must be completed and reviewed during the home study process for each prospective foster home and filed in the foster home record.

DISCLOSURE

Name of Child Placing Agency:

Name of Prospective Foster Home:

Date of Family Violence Incident:

Current Home Address:

City:

State:

Zip Code:

Telephone No. (A/C):

Home Address Where the Violence Occurred:

City:

State:

Zip Code:

Telephone No. (A/C):

Description of Incident -- Please describe the family violence, including why a report to law enforcement was made, who was involved, names and ages of all children in the home at the time of the call, and the name of anyone who was arrested. Please attach a separate sheet of paper if more space is needed.

DISCLOSURE

Name of Child Placing Agency:				
Name of Prospective Foster Home:			Date of Family Violence Incident:	
Current Home Address:	City:	State:	Zip Code:	Telephone No. (A/C):
Home Address Where the Violence Occurred:	City:	State:	Zip Code:	Telephone No. (A/C):

Description of Incident -- Please describe the family violence, including why a report to law enforcement was made, who was involved, names and ages of all children in the home at the time of the call, and the name of anyone who was arrested. Please attach a separate sheet of paper if more space is needed.

SIGNATURES

The information given is true and complete to the best of my knowledge. My failure or refusal to provide the requested information or sign this form constitutes good cause not to verify my home.

Prospective Foster Parent: X	Date Signed:
Prospective Foster Parent: X	Date Signed:

CPA USE ONLY

Name of CPA Staff who Reviewed:		Local Law Enforcement Check Required:
Date Reviewed:	Local Family Violence Check Completed:	If a Local Check was Completed, Date Shared with Licensing:



Disaster and Emergency Form

Name of Family: _____

1. Identify where you would go in case of an emergency evacuation of your home.

Type of place: (i.e. relative/friend, shelter, hotel) _____

Contact name: _____

Full address (including zip code and country):

Phone Number: _____

2. Identify where you would go in case of an emergency evacuation of your entire city.

3. Type of place: (i.e. relative/friend, shelter, hotel) _____

Contact name: _____

Full address (including zip code and country):

Phone Number: _____

4. What are two emergency phone numbers where you could be reached (not including your own):

Phone Number 1: _____

Phone Number 2: _____

I/We understand that as a foster family I/we are required to follow local and state evacuation procedures.

I/We understand that in any emergency situation, I/we must maintain appropriate supervision of all children at all times.

I/We will utilize all resources for emergency assistance including local law enforcement and/or EMS as needed.

Applicant 1 Signature

Date

Applicant 2 Signature

Date



Adult Medical Form

Patient Information:		
Full Name:	Phone: () -	
Address:		
City:	State:	Zip:
Doctor Information:		
Name:	Phone: () -	
Address:		
City:	State:	Zip:

Patient Age: _____ years Patient Height: _____ ft. _____ in. Patient Weight: _____ lbs.

Blood Pressure Reading: _____

Date of most recent medical examination: _____

General Physical Health at time of Exam: _____

General Emotional Health at time of Exam: _____

Has patient ever been hospitalized for mental health condition or diagnosis? YES NO

If yes, please explain: _____

Length of time this patient has been treated by you? _____

Does the patient have trouble sleeping?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the patient tire easily?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does this patient have frequent headaches?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Has this patient ever had:

Allergies (asthma, eczema, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Physical Handicap	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Psychiatric Treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medical Discharge from Service	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Has this patient ever been treated for:

- | | | |
|--------------------|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tuberculosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart Condition | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ulcers | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Alcoholism | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Addiction concerns | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If any question has been marked "YES", please use the space below to elaborate: _____

Is this patient currently free of any communicable diseases? YES NO

Is this patient suffering from any disease or physical or emotional handicaps that would make it impossible for him/her to give adequate care to a child? YES NO

If yes, explain: _____

Please explain any positive findings in your examination not already covered. _____

Do you consider, in view of the knowledge you have of this patient, his/her prognosis for future health, home situation and marital adjustments, that he/she is physically, mentally and emotionally competent to undertake the care and training of a foster child? _____

Other comments: _____

Physician's Signature

Date

11. What is your daily schedule? Do you have any flexibility in your schedule? For example, if necessary, can you leave work to take a child to doctor/therapy appointments, school meetings, biological family/sibling visits?

12. Give three words that describe you and your personality.

13. What are your life goals?

14. What would you consider your greatest accomplishment?

15. Do you have any regrets?

16. Do you take any medications daily?

17. If so, please list the medications and the dosage you take?

Medication Name	Dosage	Why is medication prescribed?

18. How did you hear about Arrow?

19. What is your greatest fear about fostering/adopting children?

20. Where do you attend church?

21. Are you willing to participate in and embrace our parent training, which is Biblically based and is designed from a Christian worldview?

22. Please compose a brief statement of your religious faith.

INFORMATION ABOUT FAMILY OF ORIGIN:

1. Complete the following with information about your parents and step-parents.

Name (Parents & Step-Parents)	Age	Residence	Marital Status	Name of Child & age	Frequency and type of contact

2. Describe your father's personality.

3. Describe your mother's personality.

4. How long have your parents been married?

5. Describe your parents' marriage.

6. What was the role of each of your parents in the family unit?

7. What did you like best about your father?

8. What did you like best about your mother?

9. How did your parents communicate with each other and their children?

10. If you could change anything about your father, what would it be?

11. If you could change anything about your mother, what would it be?

12. Describe how you were disciplined as a child and teenager.

13. Who enforced discipline in your home?

14. If your parents divorced, why did they divorce? Did your father remarry? Did your mother remarry?

15. If your parents remarried, did you have a relationship with your step-parent? Please describe this relationship.

16. Complete the following information regarding your siblings, half-siblings, and step-siblings.

Name	Age	Residence	Marital Status	Name of Child & age	Frequency and type of contact

17. Describe your relationship with your siblings during childhood.

18. Describe something unique or unusual about your childhood home.

19. Describe your support system (family, friends, church, neighbors, and extended family).

20. Who would you call to help watch your children in the event of an emergency, include name and relationship?

**Please note that individuals will need to complete a background check and babysitter requirements.*

21. What is their role in helping and supporting your family?

22. What are your extended family's feelings about your providing foster/adoptive care?
23. What types of questions or concerns have they had as you have gone through this process?

CHILDHOOD AND TEEN YEARS:

1. Where were you born?
2. Where did you grow up?
3. Please share some of your happiest childhood memories.
4. Describe some of your hardest times as a child or adolescent? (For eg: marital strife in family, illness, mental health issue, family divorces, abuse, deaths, moves)
5. Describe your school experience. (Include grades, extracurricular activities, relationships with teachers and friends, ect.)
6. Did you have household chores or were you expected to work as a child/adolescent?
7. As a child what did your family do for fun and entertainment? Describe your family activities.
8. What were your interests as a child?
9. How old were you when you left home? Why did you leave? How did your family feel about you moving away?
10. Was anyone in your family, including you, abused emotionally, physically, or sexually? If so, please explain the abuse and how did you cope.

11. Overall, how do you feel about your childhood and adolescent years?

MARITAL RELATIONSHIP:

1. How did you meet your spouse?

2. What attracted you to your spouse?

3. How long did you and your spouse date before marrying?

4. When and where did you marry? (Include the name of the city, state, and county where you married.)

5. Who was present at your wedding?

6. Describe your marriage.

7. Have you or your partner ever been involved in an emotional or physical extramarital relationship during your relationship/marriage?

8. Who was involved in the extramarital relationship?

9. If yes, when did the relationship occur and how long did it last?

10. If yes, is your partner aware of the relationship?

11. If yes, what actions were taken to maintain your marriage? (i.e. Did you attend counseling?)

12. If yes, do you believe you and your partner have a healthy marriage after overcoming the relationship?

13. Do you and your spouse have any contact with the individual involved in the relationship?

14. Describe the division of labor in your household.

15. How do you and your spouse communicate?

16. How are financial decisions made in your home?

17. What has led you as a couple to decide to foster and/or adopt?

18. What are your hopes in fostering and/or adopting?

19. What are your fears in fostering and/or adopting?

IF SINGLE:

1. Are you currently in a relationship?

2. Please describe this relationship.

HOME ENVIRONMENT: (The following questions must be completed by one applicant only.)

1. Describe your neighborhood, including the average income level, age of residents, and racial makeup.

2. What Independent School District are you in?

3. Are there parks or places for children to play in your neighborhood?

4. Is there adequate room to play both inside and outside your home?

5. Describe your relationship with your neighbors.

6. How long have you lived in your home?

7. Do your neighbors know that you are planning on fostering/adopting?

8. What are your neighbors' feelings about you fostering/adopting?