

**ATTACHMENT I**

**APPLICATION FOR ADOLESCENT FOSTER CARE PROVIDER LIST  
FOR THE DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES**

AGENCY NAME: \_\_\_\_\_

EXECUTIVE DIRECTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: \_\_\_\_\_

CONTACT PERSON (If different from above)

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

Position: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

E-MAIL \_\_\_\_\_

ORGANIZATIONAL STATUS: \_\_\_\_\_ NON PROFIT: \_\_\_\_\_

YEAR AND STATE OF INCORPORATION: \_\_\_\_\_

FEDERAL EMPLOYEE IDENTIFICATION NUMBER: \_\_\_\_\_

GEOGRAPHIC AREA TO BE SERVED: \_\_\_\_\_

IS THE AGENCY PRESENTLY LICENSED AS A CHILD PLACING AGENCY? \_\_\_\_\_

NUMBER OF YEARS EXPERIENCE WITH FOSTER CARE SERVICE PROVISION: \_\_\_\_\_

IDENTIFY SPECIALIZED FOSTER CARE SERVICES OFFERED \_\_\_\_\_

\_\_\_\_\_

WHICH PROVIDER LIST DO YOU WANT TO BE PART OF? (please check all that apply)

\_\_\_\_\_ DCYF Maintained Foster Homes

\_\_\_\_\_ Private Agency Maintained Emergency Foster Homes

\_\_\_\_\_ Private Agency Maintained Transitional Foster Homes

# ATTACHMENT IA

## ASSURANCES

The following contains a list of assurances. Please read them carefully. The entire list, signed by an authorized program official, must accompany your application. The signature indicates that the program and its staff are prepared to assume full responsibility for these assurances.

Failure to sign this assurance list will eliminate the application from review and consideration for funding.

This program, as indicated by the signature of an authorized program official:

1. Agrees to comply with all State regulations, standards and codes.
2. Assures that it give access to duly authorized representatives of the State to any books, documents, papers and records or those of its sub-grantees, which are pertinent to this procurement and expenditures there under, for the purpose of making audit, examination, excerpts and transcripts.
3. Assures that the Provider agrees to comply with the requirements of
  - (1) Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.);
  - (2) Section 504 of the Rehabilitation Act of 1973, as amended (29 USC 794);
  - (3) the Age Discrimination Act of 1975, as amended;
  - (4) the Department of Health and Human Services implementing regulations found in 45 CFR, Parts 80, 84 and 91; and
  - (5) Governor's Executive Orders, Number 85-11 and 85-13 which prohibit discrimination on the basis of race, sex, age, national origin, color, religion, handicap or political belief in acceptance for or provision of service or employment in the program and activities, and which mandate employers to maintain a working environment free of discriminatory insults, intimidation and other forms of harassment, including sexual harassment.

Copies of the above-mentioned requirements shall be made available at the Department.

4. Assures to engage a certified public accountant to perform a post-audit of the operations of the Provider's program under this Contract, in accordance with OMB circular A-128 and A-110 uniform requirements for grants to universities, hospitals and other non-profit organizations.
5. Assures that it will establish a client record system to document and monitor client care. This system must comply with all Federal and State reporting and confidentiality requirements.
6. Assures that quarterly reports or any other reports required will be sent on time to the grantor from the sub-grantee.
7. Agrees to protect the human rights of its clients by having an independently constituted advisory committee reflecting community values and norms to approve of all program components affecting the rights of the individual client.

**ATTACHMENT IA**  
(continued)

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Program title

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Signature of applicant

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(Type or print name of applicant)

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Signature of Authorized Program Official

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(Type or print name of program official)

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Title

---

Date

**ATTACHMENT 11**

**DEPARTMENT FOR CHILDREN, YOUTH AND FAMILIES**  
**APPLICATION FOR BOARDING CHILDREN (#036)**  
**PLEASE PRINT!**

**Please check one of the following:**

- License (Non-relative)
- License (Relative)

- Re-license (Non-relative)
- Re-license (Relative)

**Name of Children**

_____	<b>DOB</b>
_____	<b>DOB</b>
_____	<b>DOB</b>

**Degree of Kinship**

**Documentation Used  
(Attach Copy)**

**1. Applicant #1:**

_____	_____	_____	_____	_____
<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Maiden</b>	<b>DOB</b>
_____	_____	_____	_____	_____
<b>Social Security No.</b>	<b>Race</b>	<b>Hispanic - Y/N</b>	<b>Religious Affiliation</b>	

**2. Applicant #2:**

_____	_____	_____	_____	_____
<b>Last Name</b>	<b>First</b>	<b>Middle</b>	<b>Maiden</b>	<b>DOB</b>
_____	_____	_____	_____	_____
<b>Social Security No.</b>	<b>Race</b>	<b>Hispanic - Y/N</b>	<b>Religious Affiliation</b>	

**3. Address:**

_____	_____	_____
<b>Number and Street</b>	<b>City or Town</b>	<b>Zip Code</b>

**4. Directions to your home:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Telephone Number(s):**

<b>Home</b> _____	<b>Work</b> _____	
	<b>Applicant #1</b>	<b>Applicant #2</b>

**6. Date and Place of Marriage:**

\_\_\_\_\_  
\_\_\_\_\_

7. Date(s) and Place(s) of any previous marriages and divorces (please include all previous married names): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Please provide the following information about all your child(ren), regardless of age:

Last Name	First	Middle	DOB	Sex	In Home ? Yes or No	
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO
					<input type="checkbox"/> YES	<input type="checkbox"/> NO

9. Please list other members of your household (including foster children):

Last Name	First	Middle	DOB	Relationship to you

10. Language spoken in the home? \_\_\_\_\_ Interpreter Needed? \_\_\_\_\_

11. Please list your employment history for the past three years.

Applicant #1:

<u>Employer</u>	<u>Address</u>	<u>Dates</u>	<u>Position</u>	<u>Work Days/Hours</u>

Applicant #2:

<u>Employer</u>	<u>Address</u>	<u>Dates</u>	<u>Position</u>	<u>Work Days/Hours</u>

12. Do you have any other source of income?  YES  NO  
 If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. Have you, your partner, your child(ren), or any member of your household had any previous involvement with DCYF, including Juvenile Correction/Probation?

YES  NO

If yes, please explain: \_\_\_\_\_

14. Address for the Past 3-5 Years

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Have you, your partner, your child(ren), or any member of your household had any previous involvement with any Human Service Agency (Mental Health Clinic/Facility, Family Service Agency, Counseling Center, State Agency, etc.)?  YES  NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

16. Have you, your partner, your child(ren), or any member of your household ever been arrested, or charged by the police or been arraigned, indicted, or convicted of any offense ?

YES  NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

17. Do you or your partner have any chronic physical handicap or illness?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

18. Please list below all physicians with whom members of your family are involved:

Physician Address Family Member Reason

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Please sign and date the enclosed Physician's Reference (DCYF #37), and return it with this application.

20. Do you own a gun?  Yes  No

If yes, please describe method of storage so as to be inaccessible to children:

\_\_\_\_\_  
\_\_\_\_\_

21. Was your residence built after 1978?  Yes  No

22. Do you own your own home?  Yes  No
23. Type of Housing (check all that apply): Single family  Multi-family  Section 8   
Public housing  Subsidized housing
24. How many rooms in your home? \_\_\_\_\_ How many bedrooms? \_\_\_\_\_
25. What is your preference about children you would be willing to take into your home?  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Undecided \_\_\_\_\_
26. Have you ever cared for a child in your own home who is not related to you by blood or marriage?  
 Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 or certification if it has been issued. I/We further understand that all members of my/our household will be cleared through the Division of Criminal Identification records and/or the local law enforcement authority and the records of the Department for Children, Youth and Their Families.**

\_\_\_\_\_  
**Applicant #1**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Applicant #2**

\_\_\_\_\_  
**Date**

**ATTACHMENT 111A**

**STATE OF RHODE ISLAND  
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES**

**AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION**

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Client's Address: \_\_\_\_\_ SS#: \_\_\_\_\_  
\_\_\_\_\_

I authorize The Rhode Island Department of Children, Youth and Families to:

**OBTAIN FROM:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

The following information contained in records pertaining to services provided on or about  
(Start Date) \_\_\_\_\_ (End Date) \_\_\_\_\_

Please check the appropriate information to be released:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> discharge summary         | <input type="checkbox"/> financial           | <input type="checkbox"/> substance abuse treatment |
| <input type="checkbox"/> psychiatric evaluation    | <input type="checkbox"/> housing             | <input type="checkbox"/> laboratory data           |
| <input type="checkbox"/> assessment/progress notes | <input type="checkbox"/> educational         | <input type="checkbox"/> HIV/AIDS data             |
| <input type="checkbox"/> treatment/case plan       | <input type="checkbox"/> psychological tests | _____  |
| <input type="checkbox"/> medical                   | <input type="checkbox"/> other (be specific) | _____  |

Information can be released via: (*check all that apply*)

- fax  written materials  electronic mail  telephone  direct contact  other (be specific)

This information is needed for the following purpose (s):

- Case assessment/investigation  Ongoing services  Other (be specific) \_\_\_\_\_

I understand that my records are processed under RI General Law and **cannot be disclosed without my written consent except as otherwise specifically provided by law**. I also understand that if my records involve alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under **Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23**.

I release the Rhode Island Department of Children, Youth and Families (DCYF) and its employees from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This consent will have a duration of **no longer than one (1) year from the date of this form**. I understand that **I may withdraw my consent (in writing to \_\_\_\_\_ ) at any time except to the extent that action has been taken in reliance on it**.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign the authorization. I need not sign this form in order to receive services from DCYF. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

**ATTACHMENT 111A**  
**(continued)**

**I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information (including HIV test results and alcohol and drug abuse records if checked above) to those persons/agencies named above.**

\_\_\_\_\_  
Signature of Client/Legal Guardian or Parent

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date Signed

**Physician's Reference**

Date: \_\_\_\_\_

An application has been received from \_\_\_\_\_  
Name

Address

to be foster parents. As this is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of its applicants.

In order that we may expedite the processing of the application, we ask that you complete this form at your earliest convenience and return it to: \_\_\_\_\_

Do you consider the applicant physically, mentally, and emotionally competent to be a foster parent?  
 Yes  No

If no, please explain: \_\_\_\_\_

Does the applicant have any chronic disease or illness  Yes  No  
If Yes, please explain: \_\_\_\_\_

What is your impression of the applicant's general health? \_\_\_\_\_

Any additional comments? \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

I hereby authorize the Rhode Island Department of Children, Youth and Families to obtain from  
(Physician's Name) \_\_\_\_\_

Address

medical and/or psychiatric information pertinent to me for the purpose of processing my application to be a foster parent. I understand any information release or obtained will not be released further. I understand that my consent can be terminated at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

(DCF#037)

**ATTACHMENT IV**

**DATE:** \_\_\_\_\_

TO: Attorney General  
Youth  
Division of Criminal Investigation  
150 South Main Street  
Providence, RI 02903

FROM: Department of Children,  
and Families  
101 Friendship Street  
Providence, RI 02903

**SUBJECT: REQUEST FOR CRIMINAL RECORDS AS MANDATED BY RIGL 14-1-34,15-7-11**

**Household:**

**Address:**

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Number and Street	City or Town	State	Zip Code
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**\*** **Father:**

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Last Name	First	Middle	DOB
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**\*** **Mother:**

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Last Name	First	Middle	DOB
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**Other Adults Living in the Household (18 Years or Older):**

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Last Name	First	Middle
DOB		

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Last Name	First	Middle	DOB
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Last Name	First	Middle
DOB		

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Last Name	First	Middle
DOB		

\* Insert Natural, Step, Adoptive, Foster as appropriate.

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Name of Supervisor	Signature of Supervisor	Code
Bldg.		

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Name of Worker	Signature of Worker	Code
Bldg.		

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**ATTORNEY GENERAL'S OFFICE USE ONLY**

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02/97)

(DCF #034 - Revised

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**FOR ATTORNEY GENERAL'S OFFICE USE ONLY (CONTINUED)**

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ATTACHMENT V  
RHODE ISLAND DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES



Home study  
 prepared by  
 department of children, youth and families  
 010 FRIENDSHIP STREET  
 providence, rhode island 02903

Licensing Worker's Name:	
Date(s) of Visit:	
Case #:	
Certification for Name:	

(If applicable)

**Applicant #1**

Last		First		Middle	
Maiden		DOB			

**Applicant #2**

Last		First		Middle	
Maiden		DOB			

Address:

Religious Affiliation:

Motivation to Care for Children:

Your Children:

	<u>Name:</u>	<u>D. O. B.:</u>	<u>In Home:</u>	<u>School/Occupation:</u>
1.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
2.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
3.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
4.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
5.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
6.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
7.			Yes <input type="checkbox"/> No <input type="checkbox"/>	
8.			Yes <input type="checkbox"/> No <input type="checkbox"/>	

	Other Household members:	Relationship:
1.		
2.		
3.		
4.		

Present Domestic Partner:	D. O.B.
_____	

Current and Prior Marriages/Significant Relationships:

Parenting Experience (Including developmental/behavioral problems and course of action):

Describe Discipline Methods:

Family Background:

Applicant #1 Name:

Parents:

	Name	Age	Living/ Deceased	Occupation	Marital Status	Location
Father						
Mother						

Siblings: \_\_\_\_\_

	Name	Age	Living/ Deceased	Occupation	Marital Status	Location
1.						
2.						
3.						
4.						
5.						
6.						

Other Siblings: \_\_\_\_\_

Describe Relationships:

Education:

Health ( Physical/Emotional):

Use of Drugs, Alcohol, Tobacco:

Military: Yes  No

Branch: Honorably Discharged: Yes  No

Employment History:

Family Background:

Applicant #2 Name:

Parents:

	Name	Age	Living/ Deceased	Occupation	Marital Status	Location
Father						
Mother						

Siblings:

	Name	Age	Living/ Deceased	Occupation	Marital Status	Location
1.						
2.						
3.						
4.						
5.						
6.						

Describe Relationships:

Education:

Health ( Physical/Emotional):

Use of Drugs, Alcohol, Tobacco:

Military: Yes  No

Branch: Honorably Discharged: Yes  No

Employment History:

Housing:

<u>Type of Home:</u>		<u>Own/Rent:</u>			
<u># of Rooms:</u>		<u># of Bedrooms:</u>		<u># of Bathrooms:</u>	

Sleeping Arrangements:

<u>Bedroom #1:</u>		<u>Bedroom #2:</u>	
<u>Bedroom #3:</u>		<u>Bedroom #4:</u>	

Length at this Address:

Yard      Yes  No       Fence    Yes  No

Finances:

<u>Sources of Income:</u>	<u>Amount:</u>
<u>Expenses:</u>	

What are your feelings about working with the biological parents of foster children?

Safety Issues:

Do you own a gun or other weapon?      Yes  No

Ammunition is stored separately, under lock, in a place that is inaccessible to children: Yes  No

Is there a swimming pool on the property? Yes  No

If yes, it is securely fenced off from the outdoor play area to prevent access by the children:

Yes  No

Drugs and medicines are stored out of reach of children, in their original containers, and away from items which attract children such as food or candy: Yes  No

Cleaning materials, detergents, aerosol cans, matches, and other substances which could be a danger to children are stored out of reach of children, in their original containers: Yes  No

—

Describe any animals/pets in the home:

Rabies shot? Yes  No  Is the animal(s) licensed? Yes  No

—

Has your home been inspected for lead contamination? Yes  No

The Foster Care Home Agreement was reviewed and signed, which includes cooperation with permanency planning, case planning and the prohibition against corporal punishment.

Yes  No

Issues of Loss and Separation were discussed: Yes  No

MEPA Yes  No

WIC/ Food Stamps Programs: Yes  No

Impressions/Recommendations: