Dear Applicant,

Becoming a Supports for Community Living (SCL) Waiver foster care provider is an extremely demanding *and* rewarding endeavor. R.E.A.C.H. of Louisville is very happy you have chosen to apply with us. While the application process may seem very detailed and lengthy, we will help you with each step. Enclosed are some of the initial required application materials to be considered as a foster care provider:

1.  SCL Screening Questionnaire

2.  Two personal reference forms (employer, friend/neighbor etc.)

3. Child abuse registry check forms for *all adults and adolescents (12 – 17 years old)* in your home.

4.  Confidentiality agreement

5.  Health statement forms *for all persons (including children)* who are living in your home. The first page must be filled out and signed by a licensed healthcare professional.

6. TB test documentation *for all adults* in your home

We have also included a copy of a “Documentation Checklist.” This shows other paperwork and training items we will be completing. You do not need to do anything with this paper, it is just included for your reference.

If we have not already spoken prior to you receiving this packet, please call us after you receive it. This will give us a chance to answer any initial questions, review the certification process in more detail, and begin to arrange the initial training activities.

Thank you for your time and commitment. We look forward to getting to know you.

501 Park Avenue

Louisville, KY 40208

(502)585-1911

## SCL Foster Provider Initial Application Documentation Checklist

### Applicant Name:

### Address:

Phone:

Email:

|  |  |  |
| --- | --- | --- |
| **Item** | **Date Rec’d** | **Other Information/Notes** |
| **Initial Home Study**  |  |  |
| **SCL Provider Questionnaire** |  |  |
| **Personal Reference**  |  | Employer, co-worker or friend |
| **Personal Reference**  |  | Employer, co-worker or friend |
| **Medical HX and Provider Statement Form** **TB Test**  |  | Medical form for all individuals in home (including adult “non-service” providers and children). TB: all adults in home |
| **Child/Adult Abuse registry** check form mailed in by REACH staff |  | DPP 156: all adults and adolescents (12-17 yo) in the home |
| **Administrative Office of the Courts (AOC) Criminal records** check completed online by REACH staff  |  | All adults in home.  |
| **Confidentiality Agreement** |  | All providers |
| **Physical Environment Checklist** |  |  |
| **Drivers License**  |  | Current copy required |
| **Driving Record** check completed online by REACH staff |  | Initial  |
| **Proof of Car Insurance**  |  | Current copy required |
| **Initial Training** |  | See SCL training requirement document |
| **CPR**  |  | Current copy required |
| **First Aid**  |  | Current copy required |
| **CPI**  |  | Initial Post-test proof required in file  |
| **Contract** |  |  |
| **Nursing Aide Registry** check completed online by REACH staff |  | Initial  |

**SCL Foster Care Provider Questionnaire**

Please answer all the questions as honestly as possible. Feel free to use another sheet of paper for any answers you feel don’t provide enough space to respond. All of your responses will be kept confidential. Return your completed questionnaire in the enclosed envelope.

**Applying to be (circle one)?** Full-time foster provider Respite provider

**Background Information:**

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_

If married, please complete the following section:

How long have you been married? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous marriages? \_\_\_\_\_\_\_\_ How many? \_\_\_\_\_\_

Spouse’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s birth date: \_\_\_\_\_\_ Spouse’s age: \_\_\_\_\_\_\_\_\_\_

Spouse’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (if use frequently): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Own: \_\_\_\_\_ Rent: \_\_\_\_\_ How long at this address? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lived outside Kentucky within the last 5 years? If so, where? \_\_\_\_\_\_\_\_\_\_\_\_

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

Others living with you at this address:

Names: Ages: Relationship:

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

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Are any of these people currently receiving services from community agencies? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, what agency or funding sources? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your reasons for wanting to be an SCL foster or respite provider?

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

Have you ever been a foster or respite care provider in the past? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please give the details:

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

Do you have a valid driver’s license? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you have children living outside your home? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, what are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health:**

Do you (or your spouse) have any chronic health problems for which you are under a physician’s care? (such as; diabetes, asthma, heart problems, psychiatric problems, etc.) Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes: Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you or your spouse take prescribed medications on a regular basis? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes: Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has anyone in the home ever attempted suicide? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please describe briefly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does anyone in the home smoke? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs per day? \_\_\_\_\_\_

Has anyone in the home ever received treatment for a drug or alcohol problem? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please check the most appropriate answer to describe alcohol use in your home:

No use \_\_\_\_\_

Weekend/occasional use: \_\_\_\_\_

Less than 2 drinks per day: \_\_\_\_\_

More than two drinks per day: \_\_\_\_\_

Do you are your spouse draw disability? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Education and Employment:**

Highest grade completed: Self \_\_\_\_\_ Spouse: \_\_\_\_\_

Employment history: **Self**

Employer How long Reasons for leaving

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

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Employment history: **Spouse**

Employer How long Reasons for leaving

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

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**Legal History:**

Has anyone in your home ever been ***arrested* or *charged*** with any of the following? (please write who was charged for any items checked)

\_\_\_\_\_ shop lifting/ vandalism \_\_\_\_\_ probation/parole violation \_\_\_\_\_ drug charges

\_\_\_\_\_ forgery \_\_\_\_\_ weapons offense \_\_\_\_\_ burglary/larceny

\_\_\_\_\_ robbery \_\_\_\_\_ assault \_\_\_\_\_ arson

\_\_\_\_\_ rape \_\_\_\_\_ homicide/manslaughter \_\_\_\_\_ prostitution

\_\_\_\_\_ contempt of court \_\_\_\_\_ disorderly conduct \_\_\_\_\_ DUI, AI, PI

How many of these charges resulted in ***convictions***? \_\_\_\_\_\_\_\_\_\_

Has anyone in the home ever been ***accused*** of child abuse or neglect? Yes: \_\_\_\_\_ No: \_\_\_\_\_

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

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**Social:**

Do you identify yourself as being a member of a specific religion? (If so, which?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you attend religious services regularly: \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of Church:

Please list any school, community, volunteer, or church organizations to which you belong.

# Organization How long involved? Any office held

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

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What are your hobbies or interests?

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

**HEALTH EVALUATION FORM (#1)**

Name (First, Middle, Last) Date of Birth Sex

Address: Street City Zip Code

# THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

Note: The person named above has applied to become a foster parent or respite provider. Our agency serves children and adults who come from chaotic family backgrounds and exhibit pronounced emotional and behavioral problems.

As part of the application process, each member of the applicant’s household is required to obtain a physician, nurse clinician under the supervision of a physician, or a nurse practitioner’s statement certifying that the applicant meets the following criteria:*(please check the appropriate answer)*

The applicant:

1. is considered free of communicable or infectious disease. \_\_\_\_\_yes \_\_\_\_\_\_no

2. has no known physical or mental condition which would

be hazardous to, or impact negatively on another individual \_\_\_\_\_yes \_\_\_\_\_\_no

3. is considered able to accept responsibility for the care of another

individual without risking his/her own health. \_\_\_\_\_yes \_\_\_\_\_\_no

4. is currently on a prescription medication(please list meds on next line) \_\_\_\_\_yes \_\_\_\_\_\_no

Prescribed medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date of the applicant’s last physical examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this person have or has previously had a health condition, physical limitation, mental illness, alcohol or other drug problem, or any other relevant health condition that would present a health or safety risk to any person placed in their home or that would interfere with the person’s ability to provide satisfactory family foster care? \_\_\_\_\_\_yes \_\_\_\_\_\_no

HEALTH CARE PROFESSIONAL’S STATEMENT:

Based upon my knowledge of this patient and the health history reported by the applicant, I find that she/he is physically and mentally capable to be certified as a foster care provider and meets the guidelines outlined above.

Comments:

Health Care Professional’s Signature Title Date

Address Phone Number

THIS SECTION TO BE COMPLETED BY THE APPLICANT/PATIENT

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

GENERAL:

MIGRAINES OR SEVERE HEADACHES \_\_\_\_\_YES \_\_\_\_\_NO

SEIZURES, CONVULSIONS, EPILEPSY \_\_\_\_\_YES \_\_\_\_\_NO

DIABETES, SUGAR IN BLOOD OR URINE \_\_\_\_\_YES \_\_\_\_\_NO

UNUSUAL LUMPS \_\_\_\_\_YES \_\_\_\_\_NO

ARTHRITIS, JOINT PAINS, GOUT \_\_\_\_\_YES \_\_\_\_\_NO

EMOTIONAL PROBLEMS, DEPRESSION \_\_\_\_\_YES \_\_\_\_\_NO

ATTEMPTED SUICIDE \_\_\_\_\_YES \_\_\_\_\_NO

EYES: BLURRING, CHANGING VISION \_\_\_\_\_YES \_\_\_\_\_NO

GLAUCOMA, CATARACTS \_\_\_\_\_YES \_\_\_\_\_NO

EARS: TROUBLE HEARING, RINGING \_\_\_\_\_YES \_\_\_\_\_NO

HEART: CHEST PAIN, SHORTNESS OF BREATH \_\_\_\_\_YES \_\_\_\_\_NO

BLOOD/CIRCULATION:

HIGH BLOOD PRESSURE \_\_\_\_\_YES \_\_\_\_\_NO

STROKE \_\_\_\_\_YES \_\_\_\_\_NO

VARICOSE (SWOLLEN) VEINS \_\_\_\_\_YES \_\_\_\_\_NO

BLOOD CLOTS IN LEG, LUNG \_\_\_\_\_YES \_\_\_\_\_NO

TRANSFUSIONS \_\_\_\_\_YES \_\_\_\_\_NO

HIGH BLOOD CHOLESTEROL OR FAT \_\_\_\_\_YES \_\_\_\_\_NO

LUNGS:TUBERCULOSIS \_\_\_\_\_YES \_\_\_\_\_NO

ASTHMA, PNEUMONIA, EMPHYSEMA \_\_\_\_\_YES \_\_\_\_\_NO

BLACK LUNG DISEASE \_\_\_\_\_YES \_\_\_\_\_NO

LIVER: HEPATITIS, JAUNDICE, CIRRHOSIS \_\_\_\_\_YES \_\_\_\_\_NO

GALLBLADDER: DISEASE, STONES \_\_\_\_\_YES \_\_\_\_\_NO

ABDOMEN: ULCER, PAIN \_\_\_\_\_YES \_\_\_\_\_NO

BOWELS: POLYPS, BLOOD IN STOOL \_\_\_\_\_YES \_\_\_\_\_NO

KIDNEY OR BLADDER:

BLOOD/PUS IN URINE \_\_\_\_\_YES \_\_\_\_\_NO

FREQUENT INFECTIONS \_\_\_\_\_YES \_\_\_\_\_NO

STONES \_\_\_\_\_YES \_\_\_\_\_NO

EXTREMITIES (ARMS, HANDS, LEGS, FEET):

LOSS OF FEELING, TINGLING, BURNING \_\_\_\_\_YES \_\_\_\_\_NO

PAIN, SWELLING, TENDERNESS \_\_\_\_\_YES \_\_\_\_\_NO

AMPUTATION \_\_\_\_\_YES \_\_\_\_\_NO

SEXUALLY TRANSMITTED DISEASE \_\_\_\_\_YES \_\_\_\_\_NO

CANCER: PART OF BODY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE DIAGNOSED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITALIZATIONS (INCLUDE OPERATIONS)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MALES ONLY: HERNIA/PROSTATE PROBLEMS \_\_\_\_\_YES \_\_\_\_\_NO

LIFESTYLE

HOW OFTEN DO YOU EXERCISE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE THERE BEEN ANY RECENT OR STRESSFUL EVENTS TO YOU OR YOUR FAMILY?\_\_\_\_YES \_\_\_\_NO

DO YOU, OR HAVE YOU EVER, SMOKED? \_\_\_\_\_YES \_\_\_\_\_NO IF YES, HOW OFTEN? \_\_\_\_\_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_\_YES \_\_\_\_\_NO IF YES, HOW OFTEN? \_\_\_\_\_\_\_\_\_

DO YOU WEAR A SEAT BELT ON A REGULAR BASIS? \_\_\_\_\_YES \_\_\_\_\_NO

**SIGNATURE OF APPLICANT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Please return completed form to:

R.E.A.C.H. OF LOUISVILLE, INC.

501 Park Avenue

Louisville, KY 40208

Phone: (502) 585-1911

FAX: (502) 589-1582

**HEALTH EVALUATION FORM (#2)**

Name (First, Middle, Last) Date of Birth Sex

Address: Street City Zip Code

# THIS SECTION TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL

Note: The person named above has applied to become a foster parent or respite provider. Our agency serves children and adults who come from chaotic family backgrounds and exhibit pronounced emotional and behavioral problems.

As part of the application process, each member of the applicant’s household is required to obtain a physician, nurse clinician under the supervision of a physician, or a nurse practitioner’s statement certifying that the applicant meets the following criteria:*(please check the appropriate answer)*

The applicant:

1. is considered free of communicable or infectious disease. \_\_\_\_\_yes \_\_\_\_\_\_no

2. has no known physical or mental condition which would

be hazardous to, or impact negatively on another individual \_\_\_\_\_yes \_\_\_\_\_\_no

3. is considered able to accept responsibility for the care of another

individual without risking his/her own health. \_\_\_\_\_yes \_\_\_\_\_\_no

4. is currently on a prescription medication(please list meds on next line) \_\_\_\_\_yes \_\_\_\_\_\_no

Prescribed medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the date of the applicant’s last physical examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this person have or has previously had a health condition, physical limitation, mental illness, alcohol or other drug problem, or any other relevant health condition that would present a health or safety risk to any person placed in their home or that would interfere with the person’s ability to provide satisfactory family foster care? \_\_\_\_\_\_yes \_\_\_\_\_\_no

HEALTH CARE PROFESSIONAL’S STATEMENT:

Based upon my knowledge of this patient and the health history reported by the applicant, I find that she/he is physically and mentally capable to be certified as a foster care provider and meets the guidelines outlined above.

Comments:

Health Care Professional’s Signature Title Date

Address Phone Number

THIS SECTION TO BE COMPLETED BY THE APPLICANT/PATIENT

HEALTH HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

GENERAL:

MIGRAINES OR SEVERE HEADACHES \_\_\_\_\_YES \_\_\_\_\_NO

SEIZURES, CONVULSIONS, EPILEPSY \_\_\_\_\_YES \_\_\_\_\_NO

DIABETES, SUGAR IN BLOOD OR URINE \_\_\_\_\_YES \_\_\_\_\_NO

UNUSUAL LUMPS \_\_\_\_\_YES \_\_\_\_\_NO

ARTHRITIS, JOINT PAINS, GOUT \_\_\_\_\_YES \_\_\_\_\_NO

EMOTIONAL PROBLEMS, DEPRESSION \_\_\_\_\_YES \_\_\_\_\_NO

ATTEMPTED SUICIDE \_\_\_\_\_YES \_\_\_\_\_NO

EYES: BLURRING, CHANGING VISION \_\_\_\_\_YES \_\_\_\_\_NO

GLAUCOMA, CATARACTS \_\_\_\_\_YES \_\_\_\_\_NO

EARS: TROUBLE HEARING, RINGING \_\_\_\_\_YES \_\_\_\_\_NO

HEART: CHEST PAIN, SHORTNESS OF BREATH \_\_\_\_\_YES \_\_\_\_\_NO

BLOOD/CIRCULATION:

HIGH BLOOD PRESSURE \_\_\_\_\_YES \_\_\_\_\_NO

STROKE \_\_\_\_\_YES \_\_\_\_\_NO

VARICOSE (SWOLLEN) VEINS \_\_\_\_\_YES \_\_\_\_\_NO

BLOOD CLOTS IN LEG, LUNG \_\_\_\_\_YES \_\_\_\_\_NO

TRANSFUSIONS \_\_\_\_\_YES \_\_\_\_\_NO

HIGH BLOOD CHOLESTEROL OR FAT \_\_\_\_\_YES \_\_\_\_\_NO

LUNGS:TUBERCULOSIS \_\_\_\_\_YES \_\_\_\_\_NO

ASTHMA, PNEUMONIA, EMPHYSEMA \_\_\_\_\_YES \_\_\_\_\_NO

BLACK LUNG DISEASE \_\_\_\_\_YES \_\_\_\_\_NO

LIVER: HEPATITIS, JAUNDICE, CIRRHOSIS \_\_\_\_\_YES \_\_\_\_\_NO

GALLBLADDER: DISEASE, STONES \_\_\_\_\_YES \_\_\_\_\_NO

ABDOMEN: ULCER, PAIN \_\_\_\_\_YES \_\_\_\_\_NO

BOWELS: POLYPS, BLOOD IN STOOL \_\_\_\_\_YES \_\_\_\_\_NO

KIDNEY OR BLADDER:

BLOOD/PUS IN URINE \_\_\_\_\_YES \_\_\_\_\_NO

FREQUENT INFECTIONS \_\_\_\_\_YES \_\_\_\_\_NO

STONES \_\_\_\_\_YES \_\_\_\_\_NO

EXTREMITIES (ARMS, HANDS, LEGS, FEET):

LOSS OF FEELING, TINGLING, BURNING \_\_\_\_\_YES \_\_\_\_\_NO

PAIN, SWELLING, TENDERNESS \_\_\_\_\_YES \_\_\_\_\_NO

AMPUTATION \_\_\_\_\_YES \_\_\_\_\_NO

SEXUALLY TRANSMITTED DISEASE \_\_\_\_\_YES \_\_\_\_\_NO

CANCER: PART OF BODY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE DIAGNOSED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITALIZATIONS (INCLUDE OPERATIONS)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MALES ONLY: HERNIA/PROSTATE PROBLEMS \_\_\_\_\_YES \_\_\_\_\_NO

LIFESTYLE

HOW OFTEN DO YOU EXERCISE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE THERE BEEN ANY RECENT OR STRESSFUL EVENTS TO YOU OR YOUR FAMILY?\_\_\_\_YES \_\_\_\_NO

DO YOU, OR HAVE YOU EVER, SMOKED? \_\_\_\_\_YES \_\_\_\_\_NO IF YES, HOW OFTEN? \_\_\_\_\_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_\_YES \_\_\_\_\_NO IF YES, HOW OFTEN? \_\_\_\_\_\_\_\_\_

DO YOU WEAR A SEAT BELT ON A REGULAR BASIS? \_\_\_\_\_YES \_\_\_\_\_NO

**SIGNATURE OF APPLICANT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## Please return completed form to:

R.E.A.C.H. OF LOUISVILLE, INC.

501 Park Avenue

Louisville, KY 40208

Phone: (502) 585-1911

FAX: (502) 589-1582

# **Reference Form for Potential Service Provider (#1)**

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known the applicant?

In your opinion, why is the applicant a good candidate to work with individuals with special needs?

In your opinion, are there any reasons that the applicant should NOT be considered for working with individuals with special needs?

Please add any additional comments that would be helpful in determining the qualifications of the applicant to serve as a service provider to individuals with special needs.

Please rate the applicant on each of the following characteristics. If you are not in a position to comment on a particular quality, please leave it blank

4 = Superior 3 = Good 2 = Average 1 = Unsatisfactory

1. Personality (relationships, wholesome, warm) \_\_\_\_\_
2. Health (physical fitness, medical conditions) \_\_\_\_\_
3. Intellectual (ability to learn) \_\_\_\_\_
4. Emotional maturity \_\_\_\_\_
5. Dependability \_\_\_\_\_
6. Honesty \_\_\_\_\_
7. Common sense \_\_\_\_\_
8. Ability to work with others \_\_\_\_\_
9. Ability to get along with others \_\_\_\_\_
10. Parenting skills \_\_\_\_\_
11. Patience with children \_\_\_\_\_
12. Patience with adults \_\_\_\_\_

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

**Please return this response to:**

Steve Stratford, MSW

REACH of Louisville, Inc.

501 Park Avenue

Louisville, KY 40208

Thank you for your help.

##  Reference Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

##  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Reference Form for Potential Service Provider (#2)**

Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known the applicant?

In your opinion, why is the applicant a good candidate to work with individuals with special needs?

In your opinion, are there any reasons that the applicant should NOT be considered for working with individuals with special needs?

Please add any additional comments that would be helpful in determining the qualifications of the applicant to serve as a service provider to individuals with special needs.

Please rate the applicant on each of the following characteristics. If you are not in a position to comment on a particular quality, please leave it blank

4 = Superior 3 = Good 2 = Average 1 = Unsatisfactory

1. Personality (relationships, wholesome, warm) \_\_\_\_\_
2. Health (physical fitness, medical conditions) \_\_\_\_\_
3. Intellectual (ability to learn) \_\_\_\_\_
4. Emotional maturity \_\_\_\_\_
5. Dependability \_\_\_\_\_
6. Honesty \_\_\_\_\_
7. Common sense \_\_\_\_\_
8. Ability to work with others \_\_\_\_\_
9. Ability to get along with others \_\_\_\_\_
10. Parenting skills \_\_\_\_\_
11. Patience with children \_\_\_\_\_
12. Patience with adults \_\_\_\_\_

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

**Please return this response to:**

Steve Stratford, MSW

REACH of Louisville, Inc.

501 Park Avenue

Louisville, KY 40208

Thank you for your help.

##  Reference Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##

##  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **CONFIDENTIALITY AGREEMENT**

I understand that all information regarding any person who is currently receiving services, has received services in the past, or has received consideration for services through R.E.A.C.H. of Louisville, Inc., ***MUST*** be kept confidential by law. I understand that the information that I receive may only be used for service purposes within R.E.A.C.H. of Louisville, Inc. to carry out the recommended treatment program for an individual. All requests for information should be referred directly to:

Steve Stratford, MSW

SCL Coordinator

REACH of Louisville, Inc.

I am aware that violation of the requirement of confidentiality is punishable by a fine and/or imprisonment, pursuant to applicable State laws.

By my signature below, I hereby agree to assure the confidentiality of information I receive from others or obtain from my own observation regarding any service consumer of R.E.A.C.H. of Louisville, Inc.

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

Signature Date

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

Witness Date

DPP-157 **COMMONWEALTH OF KENTUCKY**

(R. 02/08) **CABINET FOR HEALTH AND FAMILY SERVICES**

922 KAR 1:490 **Department for Community Based Services**

 **Division of Protection and Permanency**

**CHILD ABUSE OR NEGLECT CHECK**

**922 KAR 1:490 requires each foster and /or adoptive parent applicant, and each household member who is age twelve and older, to submit to a child abuse or neglect check. 922 KAR 1:130 requires the caretaker relative, other adult members of the household and each household member age twelve and older, to submit to a child abuse or neglect check.**

[ ] Foster or Adoptive Parent Applicant [ ]  Caretaker Relative

[ ]  Household member of Applicant [ ]  Out of state request

**Personal information regarding the individual submitting to a child abuse or neglect check.**

Name:­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(first) (middle) (maiden/nickname) (last)

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_

**Please list your addresses for the last five years. Use another sheet of paper, if necessary.**

Present Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(street address) (city) (state) (zip code)

Previous Address:

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

(street address) (city) (state) (zip code)

Previous Address:

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

(street address) (city) (state) (zip code)

Previous Address:

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

(street address) (city) (state) (zip code)

Previous Address:

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

(street address) (city) (state) (zip code)

Previous Address:

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

(street address) (city) (state) (zip code)

I hereby authorize the Cabinet for Health and Family Service to complete a Child Abuse or Neglect Check and provide the results to the agency listed below. I also release the Cabinet for Health and Family Services, its officers, agents, and employees, from any liability or damages resulting from the release of this information.

The information provided is complete and true to the best of my knowledge. I understand if I give false information or do not report all of the information needed, I may be subject to prosecution for fraud.

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

signature of the individual (or parent/guardian of household member age 12-17) submitting to the check (date)

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

 witness (date)

|  |
| --- |
| **FOR COMPLETION BY THE CHILD-PLACING AGENCY**Name of agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (agency representative requesting information) (date)Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (agency representative requesting information) (date) |

 Mail completed form to: **The Cabinet for Health and Family Services**

 **Department for Community Based Services**

 **Records Management Section**

 **275 E. Main St., 3E-G**

 **Frankfort, KY 40621**

|  |
| --- |
| **Results of Child Abuse or Neglect Check**[ ]  No reportable incident found in accordance with 922 KAR 1:490.[ ]  Substantiated child abuse found Date of finding:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Substantiated child neglect found Date of finding:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Abuse or neglect finding relates to sexual abuse, sexual exploitation, a child fatality, or involuntary termination of parental rights: [ ]  Yes [ ]  NoCompleted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |