GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

MARYLAND EMERGENCY TEMPORARY LICENSE PACKET

Maryland Emergency Packets cannot be processed for Therapeutic / Specialized children

EMERGENCY TEMPORARY PROVIDER'S NAME_____

Social Worker's Name Telephone Number

Supervisory Social Worker Telephone Number

Policy allots 48 hours for this review and determination. *(THESE 48 HOURS ARE ONLY RELEVANT IF ALL THE DOCUMENTATION REQUESTED IS INCLUDED IN THE PACKET UPON RETURN AND THERE ARE NO QUESTIONS OR CONCERNS).* **NOTE: The 48 hour approval period does not begin until all required clearance results have been received from the State of Maryland.**

TO BE FILLED OUT AT TIME OF SUBMISSION....

DATE RECEIVED_____

RECEIVED BY_____
Tamara Smith-Jackson, Staff Assistant
Kinship Family Licensing Unit

COMMENTS:

200 I Street, SE
Washington, DC 20003
202-442-6000

MARYLAND
EMERGENCY TEMPORARY LICENSURE TIP SHEET

Who is eligible?

Residents residing in Maryland who meet the specifications of being a Kinship Care Provider. Please note that for the purposes of this Maryland Pilot Program, only children who are case managed by CFSA are eligible to be placed through this process. When the license is granted, the case must be transferred back to CFSA.

How do I initiate the Process?

An assigned social worker can initiate this process by downloading an Emergency Packet from the intranet or contacting Tamara Smith-Jackson on 202-727-3893. Once a packet has been obtained by the social worker, that worker then completes the packet along with the prospective provider. Once completed, the worker submits the packet to Tamara Smith-Jackson, 200 I Street, SE.

THE FOLLOWING FORMS ARE INCLUDED IN THE PACKET

Please review these forms with your client!!!!

1. **Adoption & Foster Care Application.** This form must be filled out completely by the worker

2. **The Kinship Foster Care Referral Form.** This form must be filled out completely by the worker

3. **The Application for Temporary License to Operate a Foster Home.** **Workers please note, you must allow prospective providers to read this form. They must realize that signing this form commits them to completing the process for full licensure which includes attending 30 hours of training—held during the evening hours!!!!!!!**

4. **Agency Form.**
   Policy on Discipline and Corporal (Physical) Punishment. This form must be signed by perspective provider(s).

5. **Relative Affidavit. If Applicable).** This form needs to be notarized. This form is only utilized to denote relationship to the child and should be submitted when the prospective provider is not biologically related to the child/children. This form must be completed by the biological parent or another viable adult family member to denote that the potential provider has a previous relationship with the child/children. **Again, this form is not needed if the potential provider is biologically related to the child to be placed.**

6. **Interstate Identification Index (Triple I) File Check Request Form.** Notarization is not mandatory if witnessed by a CFSA Social Worker. The Triple I form must be completed by all household members 18 years or older in its entirety and submitted along with the Emergency Temporary Packet. **A separate form must be filled out for each household member who needs to be checked.**

   - ***All household members, 18 and older, will be contacted by phone for scheduling of live scan (FBI)/fingerprints. This procedure will be done on site at 200 I St. SE.***
   - ***All adults MUST make themselves available for fingerprinting before a MD temporary license approval can be determined.***

7. **Training Letter.** This form is to be signed by the prospective providers agreeing to complete the PS-MAPP Foster Parent Training. **Please note it is the responsibility of the social worker to make an appropriate assessment as to the availability of the potential provider to attend training classes.** These classes occur mainly in the evening and child care is not provided. A temp license will not be granted unless this letter is signed.

8. **The Assessment Tool for Placement of Children in Kinship Home.** **This form is completed by a worker from the Kinship Family Licensing Unit.** This document contains a safety assessment checklist as well as a clinical narrative on the last page. **Please make sure to include sleeping arrangements, ages and sex of children already residing in the home and those to be placed.**

9. **The Maryland Child Protection Registry Clearance Form (CPR).** This form must be completed by the Child's Social Worker for all household members 18 years of age and older. This form **must be notarized. A separate form must be filled out for each household member. If the applicant has resided in Washington DC within the past 10 years then the attached DC CPC must also be completed.**

What do I do after I complete the packet?

The packet should be submitted to Tamara Smith-Jackson within the Child and Family Services Agency. Kinship Family Licensing Unit/Entry Services Division The packet will be logged and submitted for processing. The policy allots 48 hours for this review and determination. (THESE 48 HOURS ARE ONLY RELEVANT IF ALL THE DOCUMENTATION REQUESTED IS INCLUDED IN THE PACKET AND THERE ARE NO QUESTIONS OR CONCERNS).

What happens if the prospective parent is denied a license?

If the prospective parent is denied an Emergency Temporary License they do not have a right to appeal. They will receive a formal denial letter. They do have the option to pursue Regular Kinship Care Licensure.

What happens if the prospective parent is approved for licensure?

If the perspective parent is granted an Emergency Temporary License, It will be entered in to the FACES system. It is the responsibility of the worker to do a placement request to the Placement Office so that payments can begin. The perspective parent will be expected to attend the Mandatory Kinship Training Classes in there entirety.

****Please note all regulations from DCMR Chapter 60 for Licensing of Foster Homes as well as COMAR Regulations from the State of Maryland must be utilized for approval purposes.**

****Please pay special attention to space requirements regarding number of children, ages, and sex of children.**

**** Please pay close attention to number of available bedrooms.**

****Please ensure that prospective providers are able to attend class and complete the process for full licensure.**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency
200 I Street, SE
Washington, DC 20003
202-442-6000

Adoption & Foster Care

Application

I am interested in:

(Please check one) ☐ **Foster Care** ☐ **Adoption** ☐ **Kinship Care**

Applicant (Parent 1)

Last *First* *MI* *DOB* *Male/Female*

Spouse or Partner (Parent 2)

Last *First* *MI* *DOB* *Male/Female*

Address

Street *Apt #* *City/State* *Zip*

Home Phone Email address:

(Parent 1) Work Phone *(Parent 2) Work Phone*

1. How long have you lived at this address: _____
2. Do you live within a 25-mile radius of Washington DC? ☐ Yes ☐ No
3. Do you reside in Section-8 Housing: ☐ Yes ☐ No or Transitional Housing ☐ Yes ☐ No

Personal Information

	Parent 1	Parent 2
3. Place of Birth		
4. Social Security		
5. Religion		
6. Highest Grade Completed		
7. Race/Ethnic Origin		
8. Number of Bedrooms		

9. Insurance *(check all that you have)* ☐ Life ☐ Medical ☐ Auto ☐ Home

Children at Home

	Name	DOB	Gender	Relationship
A.				
B.				
C.				
D.				
E.				

Others in Home

	Name	DOB	Gender	Relationship
A.				
B.				
C.				
D.				
E.				

Sources of Income

	Parent 1	Parent 2
10. Who is your primary Employer?		
11. Annual Income		

(√ Check all that apply)

☐ Employment ☐ Self-Employment ☐ Social Security/Disability ☐ Retirement

☐ SSI ☐ TANF or AFDC ☐ Child Support ☐ Other _____

Marital Status

12. ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Dom. Partner ☐ Widowed ☐ LGBT Individual/Family (optional)

If married, date of marriage _____

Criminal History

13. Do you or anyone in your household have a trial pending for any charge? ☐ Yes ☐ No
If yes, please explain: _____

14. Have you or anyone in your household ever been convicted of a crime? ☐ Yes ☐ No
If yes, please explain: _____

15. Are you or anyone in your household currently on probation or parole? ☐ Yes ☐ No
If yes, please explain: _____

16. Have you or anyone in your household ever been investigated for child abuse or neglect?
☐ Yes ☐ No If yes, please explain: _____

Medical History

17 Does either parent have any health condition for which you are or have recently received treatment? If yes, please explain:

Parent 1 Yes ☐ No ☐	Parent 2 Yes ☐ No ☐

18. Are you currently or have you ever been an adoptive or foster parent? ☐ Yes ☐ No
If so, where and when did you adopt/foster? ☐ DC ☐ MD ☐ VA ☐ Yes Other _____
Date_____

19. Are you currently applying or have you ever applied to become an adoptive or foster parent through another agency? ☐ Yes ☐ No If yes, please explain and indicate the agency and date
If yes, please explain and indicate the agency and date: _____
_____

About the Child*(ren)* You Wish to Adopt/Foster *(check all that apply)*

Age Range	*Gender*	*Number of Children*
☐ 0 – 2 years	☐ Male	☐ one
☐ 3 – 5 years		☐ two
☐ 5 – 10 years	☐ Female	☐ three
☐ 10 – 15 years		☐ four
☐ 15 – 18 years	☐ Either	☐ five or more

20. Would you consider fostering or adopting any of the following:
☐ Children with special medical/emotional needs ☐ Teenage mothers and their children

Comments/Remarks _____

_____

_____

Please Sign:
I attest to the best of my knowledge that all of the above information is correct and complete.

_____ _____
Parent 1 Date

_____ _____
Parent 2 Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA
CHILD AND FAMILY SERVICES AGENCY

KINSHIP FOSTER CARE REFERRAL FORM

PLEASE PRINT
(The entire form must be completed prior to submission).

GENERAL INFORMATION

Date: _____

Name: _____ Telephone Number _____
(Referring Social Worker)

Name: _____ Telephone Number _____
(Supervisor of Referring Social Worker)

PROSPECTIVE KINSHIP FOSTER PARENT INFORMATION

Name(s): _____ Date of Birth: _____
(Applicant)

_____ Date of Birth: _____
Spouse's Name *(If Applicable)*

Address: _____

Home Telephone: _____ Work Telephone: _____

Name of Children: _____ _____

_____ _____

_____ _____

Relationship to Child(ren): _____

Is this a court ordered referral/commitment? Yes ☐ No ☐
(If yes, attach a copy of the court order)

Name of Judge: _____ Next Court Hearing ____/____/____

Name of Guardian Ad Litem: _____ Telephone Number: _____

Program Area: _____

Case Name: _____

Reason for Referral: _____

_____

_____

_____

Number of People in Home: _____

Number of Bedrooms in the Home: _____

Have Child Protection, Police and FBI Clearances been completed for all adults in the home over eighteen *(18)* years of age? ☐ Yes ☐ No

Did Child Protection, Police or FBI Clearances show a history of child abuse/neglect or a criminal conviction? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

List Place*(s)* of Employment: _____

_____

_____

Approximate Annual Income: $ _____
List all sources and amounts of other income

_____ $ _____

_____ $ _____

_____ $ _____

Total Other Income: $ _____

List all individuals residing in the potential foster parent's home and relationship to the applicants.

NAMES:	AGE:	RELATIONSHIP:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BIRTH PARENT INFORMATION

Name of Mother: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Name of Father: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Do birth parents support Placement Plan? ☐ Yes ☐ No

If no, please explain: _____

_____

_____

Do birth parents support Permanency Goals? ☐ Yes ☐ No

If no, please explain: _____

_____

_____

CLIENT INFORMATION

Please complete the table below by providing the following information for each child: Name, Date of Birth, Current Placement, Legal Status and Permanency Goal. For Permanency Goal, please use the following key: **R**-Reunification with Parent; **AD**-Adoption; **LC**-Legal Custody; **IL**-Independent Living; or **LTFC**-Long Term Foster Care

NAME OF CHILD	DATE OF BIRTH	CURRENT PLACEMENT	LEGAL STATUS	PERMANENCY GOAL

Is the child*(ren)* currently living with the potential foster family ☐ Yes ☐ No

Can the above permanency goal be reached in fifteen *(15)* months? ☐ Yes ☐ No

If no, please explain: _____

_____

_____

_____

_____

_____

_____

_____

DISPOSITION

THIS SECTION IS FOR AGENCY USE ONLY

Date Assigned for Training: _____

Training Commencement Date: _____

Training Completion Date: _____

Did Applicant Complete Training? ☐ Yes ☐ No

Notes: _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

APPLICATION FOR TEMPORARY LICENSE TO OPERATE A FOSTER HOME

INSTRUCTIONS:
This form is used to apply to the District of Columbia Child and Family Services Agency for a temporary license to operate a foster home.

Print or type all information.

I. Child Information *Provide the following information for each child who* ***would*** *be placed in the temporary foster home (continue on additional pages if needed).*

Full Name (last, first, middle)	Date of Birth	Sex
1.		
2.		
3.		
4.		
5.		

II: Applicant Information *Provide the following information concerning the person who is applying for the temporary license and any significant other (i.e., married or unmarried couple living together)*

1. **Full name of potential provider 1** :

Last First Middle

List **all** names ever used *(maiden, married, alias, etc.; continue on additional pages if needed)*:

Relationship to foster child:

Date of Birth:
Social Security Number:
Sex:

2. **Full name of potential provider 2:**

Last First Middle

List **all** names ever used *(maiden, married, alias, etc.; continue on additional pages if needed)*:

Relationship to foster child: _____

Date of Birth: _____
Social Security Number: _____
Sex: _____

3. **Address**:

_____

Street Apt.# City State Zip Code

4. Home Phone: _____ _____

5. Work Phone: _____ Whose: _____
_____ Whose: _____

6. Cell Phone: _____ Whose: _____
_____ Whose: _____

7. E-mail address _____ Whose: _____
_____ Whose: _____

III. Household members *(provide the following information for each household member, **other than** the potential provider(s)*

Name	Date of Birth	Sex	Relationship to applicant
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Applicant Signature and Attestation:

I understand and agree that:

1. I am applying for a temporary license to operate a foster home in order to have the child(ren) identified in Part I above, placed in my home.

2. In order for me to receive a temporary license to operate a foster home I must: receive a satisfactory criminal records check from the Interstate Identification Index System; ; comply with requirements concerning a Child Protection Register check; receive a satisfactory safety assessment of my home; and demonstrate the willingness and ability to provide a safe and secure environment for a foster child.

3. In order for me to receive a temporary license to operate a foster home all individuals eighteen (18) years of age or older residing in my home must: receive a satisfactory criminal records check from the Interstate Identification Index System; and comply with requirements concerning the Child Protection Register check.

4. If a temporary license is issued to me I will actively and promptly take all steps required for full foster home licensure.

5. A temporary license will permit me to operate a foster home prior to issuance of a full foster home license to operate a foster home and while I attempt to satisfy the requirements for a license.

6. A temporary license will expire in one hundred fifty (150) days from its effective date.

7. A foster child who is not kin to me will not be placed in my home while I have a temporary license.

The information in this Application for Temporary License to Operate a Foster Home is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature Prospective Provider 1 *Date*

_____ _____

Signature Prospective Provider 2 *Date*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

AGENCY POLICY ON DISCIPLINE AND CORPORAL (PHYSICAL) PUNISHMENT

Child and Family Services Agency is mandated by law (D.C. Law 2-22- Prevention of Child Abuse and Neglect Act of 1977) to report child abuse and neglect. According to this law, an abused child is "a child under eighteen (18) years of age whose parent, guardian or custodian inflicts or fails to make reasonable efforts to prevent the infliction of physical, mental, and/or sexual abuse or molestation." Corporal punishment means the inflicting of pain or discomfort. Prohibited actions include, but are not limited to, hitting with any part of the body or with an instrument, pinching, pulling, shaking, binding a child, forcing him/her to assume an uncomfortable position, or locking him/her in a room or closet. "Emotional neglect is a significant impairment of the child's emotional ability to function adequately and which is caused by action or inaction of person(s) responsible for his/her care."

This prohibition is in effect whether punishment is spontaneous or a deliberate technique for effecting behavior change or part of a behavior management plan.

In addition to being mandated by law, Child and Family Services Agency believes that children who have been abused (physically and sexually) and neglected, must not be subjected to corporal (physical) punishment or emotional neglect in foster or adoptive homes. Therefore, the following policy is in effect:

1. Foster parents, adoptive parents, members of their families, volunteers and other substitute caretakers (who are approved by the foster or adoptive parents and agency) **may not** use corporal (physical) punishment as a disciplinary method.

2. Foster parents, adoptive parents (and others as noted above) **may not** use emotional neglect or verbal abuse as a disciplinary method.

3. Foster and adoptive parents **may not** give others permission to use corporal punishment toward any child under the supervision of the agency's care or responsibility.

4. All instances of corporal punishment or emotional neglect must be reported to Child and Family Services Agency and the Local Social Services agency/Police department where the foster family resides.

5. Child and Family Services Agency staff is prepared to partner with foster/adoptive parents in developing appropriate methods for discipline of the foster children in their care.

6. The Child and Family Services Agency supports the judicious use of alternatives to corporal (physical) punishment such as:

   A. Be a Role Model

   B. Provide the Child with Time Out

   C. Provide Positive Reinforcers and Privileges

   D. Take away Privileges

   E. Ignore the Behavior

   F. Provide Natural and Logical Consequences

   G. Ensure that Restitution Occurs

   H. Hold Family Meetings

   I. Develop Behavioral Charts

   J. Use Grandma's Rule or This for That

   K. Help the Child Understand Feelings

   L. Replace Negative Time with Positive Time

   M. Provide Alternatives for Destructive Acting-Out Behaviors

   N. Make a Plan for Change with the Child

   O. Make a Plan for Change with the Child and a Professional

The Child and Family Services Agency Social Worker will provide additional guidance on the important role of disciplining foster/adoptive children upon request.

I have read and understand the above policy and agree to abide by it.

_____	_____	_____
Signature	Title	Date
_____	_____	_____
Signature	Title	Date

This form only has to be completed and NOTORIZED if the potential provider IS NOT biologically related to the child to be placed.

RELATIVE AFFIDAVIT

I, [_____] state that the following is true to the best of my knowledge,
Biological Parent/Relative

Information and belief:

1. I am [_____] by [_____]
Relationship to child — select one: blood, marriage or adoption

of [_____].
Child' name

[_____] is a [_____] who was born in
Child's Name — Gender

[_____].
Place of Birth

2. [_____] has a relationship with child
Prospective provider(s) name

based on [_____
]
(Explain Connection, i.e. Babysitting, weekend care, etc.)

3. [_____] has close personal and emotional ties with
Prospective provider(s) name

[_____] and with [_____], and
Child's Name — Child's Family Name

those ties pre-dated [_____]placement in CFSA's
Child's Name

custody.

[_____]
Potential Provider(s) Name

4. I hereby swear or affirm that the contents of this Relative's Affidavit are true and correct to the best of my knowledge, information and belief.

_____
[Full Name]

_____
Address

Subscribed and sworn to before me this _____ day of _____, 20 _.
Notary Public_____
My commission expires _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

NCIC

INTERSTATE IDENTIFICATION INDEX (TRIPLE I) FILE CHECK REQUEST FORM

INSTRUCTIONS:
This form is used for a Triple I Check requested in connection with either an application for a temporary license from the D.C. Child and Family Services Agency to operate a foster home.

***Each person applying for a temporarily license, as well each person living in the household (temporary or permanently) of the person who is applying to for a temporary license and who is 18 years of age or older, must receive a Triple I check. A separate form is required from each person.**

Print or type all information.

I: Person to be Checked

NAME: _____
Last First Middle

D.O.B. _____ Social Security No. ____-____-____

Race: _____ Gender: Male Female (Circle One)

List **all** names ever used *(maiden, married alias, etc.; continue on additional pages if needed)*:

_____ _____

_____ _____

II. Person(s) Applying for Temporary License

NAME: _____ D.O.B. _____
Last First Middle Initial

ADDRESS: _____
No. & Street City State

NAME: _____ D.O.B. _____
Last First Middle

ADDRESS: _____
No. & Street City State

III: Name of child (ren) to be placed in home

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

NAME _____ D.O.B. _____
Last First Middle Initial

IV: Signature and Attestation –

IF THE SIGNATURE IS NOT PERSONALLY WITNESSED BY A CFSA STAFF MEMBER, THIS FORM MUST BE NOTARIZED.

1. I understand and agree that this Triple I Check is being made in connection with the application for a temporary license to operate a foster home made by the person(s) identified in Part II, above.
2. I understand and agree that the result of the Triple I check will be provided to relevant CFSA's foster home licensing and monitoring staff, as well ass relevant staff of the child placing agency through which the licensing application is made (if different).
3. I understand and agree that the results of the Triple I check may also be shared with:
   - The individual who is applying for the temporary license to operate a foster home if the results of the check are relevant to the decision whether to grant the license;
   - The Family Court if the results of the check are relevant to the court proceedings concerning a foster child who is or would be placed in the home; and
   - CFSA Office of Hearings or the District's Office of Administrative Hearings if the results of the check are relevant to a fair hearing concerning the temporary license to operate a foster home.

The information in this Interstate Identification Index (Triple I) is true and correct to the best of my knowledge, information and belief.

_____ _____
Applicant's Signature Date

_____ _____
Social Worker's Signature Date

Subscribed and sworn to before me this_____day of _____, 20____.

_____
Notary Public

My commission expires: _____

V. *This section is to be completed by CFSA staff member*

To be completed by staff performing check:

Date of Triple I Check: _____

Person conducting Check: _____

_____ *Person is not listed*

_____ *Person is listed*

State of Maryland-Child Protective Services Program

CONSENT FOR RELEASE OF INFORMATION/BACKGROUND CLEARANCE REQUEST

INSTRUCTIONS

1. Type or print legibly in ink. INCOMPLETE FORMS WILL BE RETURNED.
2. Submit a separate form for each individual whose name is to be searched.
3. Provide proof of identify and sign Part III in the presence of a Notary Public.
4. This form must be notarized.
5. Return the completed form to either:

   Local Department of Social Services in the area where you reside

   or

   Department of Human Resources
   In-Home Services
   Social Services Administration
   311 W. Saratoga Street, Room 553
   Baltimore, MD 21201

Part I: PURPOSE OF SEARCH: ***(Complete below and the person that this search pertains to must sign the form on the reverse in part III.)***

☐ A. RELEASE TO SELF:

☐ 1. To determine if I have been found responsible for indicated or unsubstantiated disposition for a child abuse or neglect investigation.

☐ 2. To determine if I have any remaining appeal rights

☒ B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO:

☐ Foster Parent ☐ School Personnel ☐ Day Care Center
☒ Kinship Care Provider ☐ Institutional Employee ☐ Family Day Care Provider
☐ Adoptive Parent ☐ CASA ☐ Other Employment (Explain _____
☐ Custody Evaluation ☐ Volunteer ☐ Other (Explain) _____

1. Requesting Agency Or Individual Name		2. Name Of Agency Representative		
Child and Family Services Agency		Robert Matthews, Program Manager		
3. Address	City	State	Zip	Telephone
200 I Street, SE	Washington	DC	20003	202-724-8943

☐ C. RELEASE OF SUMMARY OF AGENCY FINDING:
I am aware that I have an **indicated** disposition following a child abuse or neglect investigation and I authorize the agency to release a summary to the individual/agency identified in part I as to why I was found responsible.

Part II: TO BE COMPLETED IN FULL, BY INDIVIDUAL WHOSE NAME IS BEING SEARCHED

1. IDENTIFYING INFORMATION:

Last Name | First | Full Middle | Maiden/Birth Name

Social Security # | Race | Sex | Birthdate | Other Names Used

2. CURRENT ADDRESS | City | State | Zip

3. PRIOR ADDRESS(S) AND DATE(S) *(Within The Past 7 Years)* | City | State | Zip | Date

City | State | Zip | Date

4. CURRENT SPOUSE Last, First, Full Middle | Race | Sex | Birth Date

5. PREVIOUS SPOUSE Last, First, Full Middle | Race | Sex | Birth Date

6. FULL NAMES OF ALL CHILDREN LIVING WITH YOU *(Also include adult children not living with you. Attach additional paper if needed)*

Last, First, Full Middle	Race	Sex	Birth Date	Last, First, Full Middle	Race	Sex	Birth Date

Part III: AUTHORIZATION *(Check either 1 or 2 below.)*

Pursuant to Maryland Code of Regulation Section 07.02.07.19, pertaining to the confidentiality of Child Protective Services records and reports, I hereby authorize the Maryland Department of Human Resources (DHR):

☐ 1. To **notify** _____ *(self, agency, or individual listed in part I)* as to whether a local department of social services has identified me as responsible for "indicated" child abuse or neglect in any record maintained by the Maryland DHR, any Local Department of Social Services, and Child Protective Services.

☒ 2. To **release a summary** of the indicated finding to CFSA *(self, agency, or individual listed in part I).*

SIGNATURE: *This form must sign in the presence of a Notary Public by the person named in part II.* DATE:

Part IV. CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL BEFORE A NOTARY PUBLIC

City/County of: _____ State of: _____

Acknowledged before me this _____ Day of _____ 20____

_____
Notary Public

My Commission expires: _____

Part V. BACKGROUND CLEARANCE FINDINGS *(for Local Department or DHR use only)*

☐ 1. We are unable to determine at this time if the individual for whom a search has been requested has a CPS finding. Form returned to requesting agency. Date _____

☐ 2. Sent to DHR or Local Department of Social Services: Name _____
Date _____

Date returned from Local Department _____

☐ 3. Based on information provided by Local Departments of Social Services, we have determined that _____ is listed in the Central Registry as being responsible for an ☐ Indicated/ ☐ Unsubstantiated disposition of ☐ Abuse / ☐ Neglect in reference to an investigation conducted in _____. Child Protective Service Case/File/Referral #: _____

☐ 4. Holding for Appeal Appeal Date _____ Appeal Disposition _____

☐ 5. Notification sent to Requesting Agency/Individual: Date _____

☐ 6. Notification sent to Person: Date _____

☐ 7. Summary Provided: Date _____

☐ 8. As of this date, the individual whose name was being searched is NOT identified in the Central Registry as being responsible for abuse or neglect.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Child Protection Register Check Application
License to Operate a Foster Home (CPR Check – foster home license)
EMERGENCY TEMPORARY LICENSE ONLY

This form is used for a CPR Check requested in connection an application for a license from the D.C. Child and Family Services Agency to temporarily operate a foster home.

INSTRUCTIONS: *Please PRINT or TYPE, filling in all requested information, and sign in the places marked "Applicant Signature."* ***Please do not use initials to represent your first or middle name.*** *However, if your first or middle name consists of only an initial, please indicate. A complete street address is required in addition to P.O. Box numbers.*

Each person living in the household (temporarily or permanently) of the person who is applying to be a foster parent (including a temporary foster parent) and who is 18 years of age or older, must complete a separate CPR Check Application.

PART I: Applicant Information

NAME: _____
Last First Middle

D.O.B. _____ _____ _____ Social Security No. _____–_____–_____
Month Day Year

Race: _____ Gender: ☐ Male ☐ Female

List **all** names ever used *(maiden, married, alias, etc.; continue on additional pages if needed)*:

_____
Last First Middle

_____
Last First Middle

_____
Last First Middle

_____
Last First Middle

_____
Last First Middle

PART II: Licensee Information Provide the following information concerning the individual seeking the license to operate a foster home. If the same as the person identified in Part 1, above, write "same".

NAME: _____
Last First Middle

D.O.B. _____ _____ _____ Social Security No. _____–_____–_____
Month Day Year

Race: _____ Gender: ☐ Male ☐ Female

PART III: Household Information List all persons living at the current address. Print their Name, Date of Birth, and Relationship below.

NAME (Last, First. Middle)	D.O.B	RELATIONSHIP

PART IV: Applicant Residency List all complete addresses (exclude zip code) at which the individual has resided in the past eighteen (18) years, and the dates lived there, beginning with the most recent. Continue on additional pages if needed.

No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
No. & Street (include apt. number if applicable)	City	State	Dates of Residency

PART V: Applicant Release

1. I understand and agree that this Child Protection Register Check Application – Emergency Temporary License to Operate a Foster Home is being made in connection with the application for a license to operate a foster home made by the person identified in Part II, above.
2. I understand and agree that the result of the CPR check will be provided to relevant CFSA foster home licensing and monitoring staff, as well as relevant staff of the child placing agency through which the licensing application is made (if different).
3. I understand and agree that the result of the CPR check may also be provided to relevant CFSA or contract agency staff providing case management services to a foster child who is or may be placed in the foster home.
4. I understand and agree that the results of the CPR check may also be shared with:
   - The individual who is applying for the license to operate a foster home if the results of the check are relevant to the decision whether to grant the license;
   - The Family Court if the results of the check are relevant to the court proceedings concerning a foster child who is or would be placed in the home; and
   - CFSA Office of Fair Hearings and Appeals or the District of Columbia's Office of Administrative Hearings if the results of the check are relevant to a fair hearing concerning the license to operate a foster home.

PART VI: Applicant Signature and Attestation This form must be notarized unless identification is shown to a CFSA staff member who has signed below.

The information in this Child Protection Register Check Application – License to Operate a Foster Home is true and correct to the best of my knowledge, information and belief.

_____ _____

Applicant's Signature Date

Identification has been shown to me that I have deemed satisfactorily identifies the applicant::

Type of ID _____ ID # _____

Witnessed by CFSA staff member:

_____

Name printed: _____

Title: _____

DISTRICT OF COLUMBIA:

Subscribed and affirmed or sworn to me, in my presence,

on this _____day of _____, 20____.

Signature of Notary Public

_____

Notary Public, District of Columbia

My commission expires on ___/___/____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
CHILD AND FAMILY SERVICES AGENCY
Entry Services Division

Kinship Family Licensing Unit
EMERGENCY PLACEMENT
Biometric Live scan Criminal Background Check Request Form

Booking ID # 017_____

FACES Provider ID # _____ Provider Name _____
Name that will appear on the license

Placement Child (ren):_____

Licensing SW/Requester_____ Log Date_____

Live scan Operator_____ Date Scanned_____

Applicant Types:

☐Emergency Temp Placement License ☐Backup Child Care Provider

Do you reside in the home of the Emergency Temp. License parent?

YES _____ NO_____

Name of person fingerprinted: _____
(Please Print) First Middle Last

Date of Birth: _____ **Gender:** ☐Male ☐Female ☐ **Race**_____

Height: _____ **Weight:** _____ **Eye Color:** _____ **Hair Color:** _____

Place of Birth: _____ **Country of Citizenship**_____

Social Security Number: _____

Photo ID Type: ☐Gove. ☐Military ☐Drivers ☐State ID **Number**_____

Residence of person fingerprinted_____
Street City State Zip. Code

Phone Numbers_____
Home Work *(only if you are reachable)* Cell

Please read and sign below

I confirm that the above information is true to the best of my knowledge and agree to undergo a criminal background check including but not limited to the DC Metropolitan Police Department (MPD) and the FBI.

_____
Signature of person fingerprinted:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

IN REPLY REFER TO:

Pre-Service Training Requirements for Temporary Kinship Foster Parents

I, _____ _____
Applicant 1 Applicant 2

understand and agree that I am required by Policy & Regulation to attend Child and Family Services Agency's (CFSA's) five (5) week pre-service training session for Foster Kinship/Adoptive parents.

I understand that my spouse or paramour or significant other is also required to attend this five (5) week Pre-Service Training.

I understand that these classes are held *primarily during the evening hours* and I must make the appropriate accommodations for attendance.

I understand and agree that after I get my approved Emergency Temporary License that I must call Tamara Smith- Jackson, Staff Assistant, at 202-727-3893 within four (4) days and schedule for the next available set of Pre-Service MAPP/Pre-Service Training Classes. No exceptions are made for working or taking classes in the evening.

I understand and agree that if I cannot take these training sessions a temporary license will not be granted to me.

I understand that if I fail to attend these classes after the child is placed, the child will be removed and an alternative placement for the child will be sought.

_____ _____
Applicant's Signature Date

_____ _____
Applicant's Signature Date

_____ _____
Social Worker's Signature Date

March, 2011

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

ASSESSMENT TOOL FOR PLACEMENT OF CHILDREN IN KINSHIP HOME

Date of Evaluation_____

Prospective Kinship: Provider 1 _____
Last First Date of Birth

Provider 2 _____
Last First Date of Birth

Social Security Number _____ Social Security Number_____
Provider 1 Provider 2

Complete Address: _____
Zip Code: _____

Home Telephone Number_____ Work Telephone Number_____
Provider 1

_____
Provider 2

List other occupant(s) in the home besides potential providers	Age	Date of Birth	Sex	Relationship to provider(s)

Names of Children to be placed	Age	Date of Birth	Sex	Relationship to provider (s)

Name of Child's Social Worker: _____

Phone Number: _____

Social Workers Supervisor:_____

Supervisors Phone Number: _____

Type of structure

A. House
   1.)___Attached ___Detached Duplex__Duplex
   2.)____Number of Stories (including basement/finished basement)
B. Apartment/Floor_____
C. Other (specify)

Description of Facility

Room	Size	Location	Function
Ex: bedroom 1	*11 x 17*	*2nd floor from*	*provider 1&2 room*
Bedroom 3	*11x17*	*basement*	*adult daughter's room*

Total Number of Fire Extinguishers_____
Total Number of Smoke Detectors_____

	Y	N	Comment
Home free of fire hazard	___	___	_____
Home maintained in a safe and sanitary condition	___	___	_____
Temperature Maintained at an adequate level	___	___	_____
Sufficient lighting in all rooms	___	___	_____
Sufficient ventilation in all rooms	___	___	_____
Medications, poisonous chemicals and hazardous			
Cleaning materials kept out of reach of children	___	___	_____
Home and premises free of vermin	___	___	_____
Working telephone accessible	___	___	_____
Plumbing in working order	___	___	_____
One bed/crib for each child (1)	___	___	_____
beds must be present in the home prior to submitting packet			
Adequate linens/bed coverings and pillows for each child	___	___	_____
Adequate amount of food in the home	___	___	_____
First Aid Kit available in the home	___	___	_____
Does the potential provider or anyone else residing in the home have any medical or mental health conditions that would negatively impact their ability to provide care for the child	___	___	_____
Do the pets in the home (if applicable) have current vaccinations	___	___	_____

	Results	Date Received
Police clearances available on all household members Eighteen years of age and older	_____	_____
FBI clearances available or in process on all household members Eighteen years of age and older	_____	_____
CPS Register clearances available on all household Members eighteen years of age and older	_____	_____

Amount of Household Income_____
Source of Household Income_____
Approximate monthly expenses_____

Name and Phone Number of Social Worker performing assessment _____

CLINICAL ASSESSMENT
PLEASE SUBMIT ASSESSMENT ON POTENTIAL PROVIDER FOR CONSIDERATION.
ASSESSMENT FORMAT AND EXAMPLES ARE INCLUDED IN THE PACKET

Please make a selection: must be completed by referring social worker

****Indicate with a (X)**

Passed_____ **Failed**_____

Reason_____
_____
_____
_____
_____

Social Workers Signature_____ **Date**_____

Supervisor's Signature_____ **Date**_____