

Agency Use Only Date Application Form Received: _____ Name of Staff Receiving Form: _____

Confidential

APPLICATION FORM for FOSTER CARE LICENSE

(Per Regulation at 7 AAC 50.035, if the household is headed by two adults who act as head of household, both adults must apply for the license.)

Applicant #1

Applicant #2

Last Name, First, MI:		Last Name, First, MI:	
Aliases, Maiden Name, Previous Married Name(s):		Aliases, Maiden Name, Previous Married Name(s):	
Social Security Number:		Social Security Number:	
Race (check all that apply) <input type="checkbox"/> Alaskan Native Tribe: _____ <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiaq <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> American Indian Tribe: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islands <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> CIB/BIA #: _____		Race (check all that apply) <input type="checkbox"/> Alaskan Native Tribe: _____ <input type="checkbox"/> Aleut <input type="checkbox"/> Athabascan <input type="checkbox"/> Haida <input type="checkbox"/> Inupiaq <input type="checkbox"/> Tlingit <input type="checkbox"/> Tsimshian <input type="checkbox"/> Yupik <input type="checkbox"/> American Indian Tribe: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islands <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> CIB/BIA #: _____	
Ethnic Background: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other:		Ethnic Background: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other:	
Place of Birth: _____		Place of Birth: _____	
Primary Language: _____		Primary Language: _____	
Religious Affiliation (optional): _____		Religious Affiliation (optional): _____	
Education (last grade completed): _____		Education (last grade completed): _____	
Employment Status: <input type="checkbox"/> Employed at: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in labor force (unemployed / not looking for work, retired, disabled, etc.)		Employment Status: <input type="checkbox"/> Employed at: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Not in labor force (unemployed / not looking for work, retired, disabled, etc.)	
Marital Status:		Marital Status:	
Work Phone:	Home Phone:	Work Phone:	Home Phone:
Additional Phone:	E-mail Address:	Additional Phone:	E-mail Address:
Mailing Address	City/Village	State	Zip

Alaska Department of Health and Social Services
Office of Children's Services

Street Address	City/Village	State	Zip
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Directions to home:

How long have you resided at the current address? _____

Are you located in an area susceptible to earthquakes, flooding, tsunamis, wildfires, avalanches, or other natural disasters? Yes No

Household Members (Include all individuals living in the home or on the premises full or part-time. Do not include foster children.) Attach additional page(s) if necessary.

Name	Relationship	Birth Date	Age	Driver's License #	State of Issuance
1.					
2.					
3.					
4.					
5.					
6.					

Willing to care for: Number of children: _____ Age: _____ to _____ Male Female
 Specific child(ren) only Pre Adoptive Children Only

Closest Schools

Elementary School	Middle School	High School
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Have you ever submitted/applied to the State of Alaska for any care listed below? Yes No
 Have you ever applied to another state, county, or private agency for any care listed below? Yes No

Relative Care Foster Care Adoption Guardianship Child Care

If yes:

Agency Name	Address	State	Date	Approved
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you now or have you ever provided care to non-related adults or children? Yes No

If yes, when? _____ If yes, where? _____ What type of care? _____

Have you been previously licensed to care for children or adults? Yes No
If yes, please indicate:

City	State	Type of Care	Dates of Licensure

REFERENCES (Neighbors, employer, physician, friend). Regulations require three references, at least two of whom are unrelated. If two-applicants, references must address both applicants or separate references for each applicant. Please complete all sections.

Name	Complete Mailing Address	Phone	E-Mail Address

APPLICANT CERTIFICATION AND SIGNATURE

- I (we) have read and completed this application form.
- I (we) have received a copy of the State of Alaska Child Foster Home Statutes and Regulations, or I (we) will use the web address at <http://www.legis.state.ak.us/FOLHOME.HTM> for a copy of the statutes and regulations.
- I (we) have provided a completed Clearance Form (06-9437) for each applicant and household member age 16 and older.
- I (we) will provide fingerprints and necessary background check forms within 30 days of submitting this application.
- I (we) agree and understand that I (we) will be placed on the APSIN flag system.
- I (we) authorize the OCS representative to review criminal justice (CJ), including, where applicable, juvenile criminal history, protective service, and licensing records and to share this information (except federal CJ records) with the applicant/licensee and if applicable, between OCS and the agency responsible for evaluating the facility. I certify that the contents of the forms and information provided with it are true, accurate, and complete.
- I (we) will cooperate with the licensing worker to complete the licensing requirements to become fully licensed.
- I (we) certify that the above information and any information given at a later date will be true, complete, and accurate.

<p>_____ Applicant Signature</p> <p>Date: _____</p>	<p>_____ Applicant Signature</p> <p>Date: _____</p>
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* If 2-applicants, both must sign

Office of Children's Services Use Only

License Application: <input type="checkbox"/> Initial Provisional <input type="checkbox"/> Biennial <input type="checkbox"/> Change of location <input type="checkbox"/> Change in household composition, or change of name	Specializations: <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Pregnant/Parenting Adolescents <input type="checkbox"/> Foster Group Home
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The following forms have been received and reviewed by the assigned licensing worker.

- Application Form for Foster Care License, signature of each applicant is required (06-9162).
- Application for Background Check for each household member age 16 and older.
- Release of Information Authorization for Background Check
- Clearance Form (06-9437) for the applicant(s) and each household member age 16 and older.
- Fingerprints submitted to the Background Check Program for each applicant and household member age 16 and older.
- Other
 - Background Information (P1 and P2)
 - Plan of Care
 - Characteristics Checklist
 - Copy of ADL/ID (age 16 and older)
 - Evacuation Plan
 - Provider Emergency Information Response Form
 - Three positive references for applicant

Additional information may be required if applicable that include but is not limited to.

- Request for Variance
- Health History
- Medical health Information
- Letter from Base/Post Commander
- Employees in Foster Homes
- Medical Information Release
- Well Water Test
- Fire/DEC Inspection Reports

Application was reviewed by _____
Worker Name Title

Worker Signature Date

- Application is complete
- Application is not complete

If the application is not complete, date notice sent _____