DHPPS-
CFS-090P1
07/2018

STATE OF MONTANA
Department of Public Health and Human Services
Child and Family Services Division

Resource Family Application

The estimated time for becoming a fully licensed resource parent is 6 months

CFSD Applicants:	☐ **Kinship Care (foster, adoptive, guardianship)**	**YDI, YBGR, Intermountain, Dan Fox Family Homes, Partnership for Children, New Day Applicants Only:**
☐ **Youth Foster Care**	**Name of relative child:**	☐ **Therapeutic Foster Care**
☐ **Adoption**	**Date placed in your home:**	
	Are you receiving TANF? Yes ☐ No ☐	
	Does child receive other benefits (SSI, SSB)? Yes ☐ No ☐	

Applicant #1	Applicant #2
Legal Name: Last First Middle Maiden	Legal Name: Last First Middle Maiden
Residential Address:	
Mailing Address:	
Length of time at address:	Home Phone:
Cell Phone:	Cell Phone:
Date of Birth Sex: Place of Birth(City/State) SS# Drivers Lic #	Date of Birth: Sex: Place of Birth(City/State): SS# Drivers Lic #
Are you a U.S. Citizen? Yes ☐ No ☐ If no please explain:	Are you a U.S. Citizen? Yes ☐ No ☐ If no please explain:
Employer: Occupation: May we call you at work? Yes ☐ No ☐ Work phone:	Employer: Occupation: May we call you at work? Yes ☐ No ☐ Work phone:
Hours of Work:	Hours of Work:

E-mail Address:		E-mail Address:
Last grade completed in school:		Last grade completed in school:
Marital Status:	Date of Marriage:	Place of Marriage (City/State):

Religion:	Religion:
Race/Ethnicity (check all that apply): ☐ Caucasian ☐ Hispanic Origin ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ African American ☐ Alaskan Native ☐ American Indian Enrolled Yes ☐ No ☐ Which Tribe _____ Enrollment #	Race/Ethnicity (check all that apply): ☐ Caucasian ☐ Hispanic Origin ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ African American ☐ Alaskan Native ☐ American Indian Enrolled Yes ☐ No ☐ Which Tribe: _____ Enrollment #

Have you experienced any major life changes within the last 12 months, such as:

a. ☐ Loss of employment or serious financial difficulties
b. ☐ Marital counseling
c. ☐ Marital separation
d. ☐ Divorce
e. ☐ Death of a spouse or child
f. ☐ Birth or adoption of a child
h. ☐ Other

Have any of your own birth children been in foster care? (If Yes, please explain in Section below)
Yes ☐ No ☐

(Please use this section below to explain any yes answers above)

Type/age/name of child(ren) applying to provide care for:

_____	_____	_____
Age Range	**Sex**	**Number**

For Adoptive applicants (CFSD or Kinship only) :
Are you interesting in adopting a sibling group? Yes ☐ No ☐.

If Yes, how large of a sibling group would you consider for placement? _____

Please provide the following information related to all your children (minor and adult):

Name	Birth Date	Age	Birthplace	Last grade completed in school	Race/Ethnicity and if applicable, Tribal affiliation	Relationship (i.e. son, dau)	Does child live with you?

Please provide the following information on all ***others*** in household (besides applicants) : *(all household members 18 and older must have fingerprints completed.*

ARM 37.51.305(2) defines household members as any person staying in your household two weeks or longer).

Name	Birth Date	Grade in School or Occupation	Relationship

Attach additional sheets if necessary

Please list four (4) references: [Required for initial application and as requested by the Department]

***Only one reference may be a relative to applicant*(s)**

Please provide complete Information

	Name	Complete Mailing Address including City, State and Zip	Telephone	E-mail Address	Relationship
1.					
2.					
3.					
4.					

Contact information for All Adult Children of applicants (add additional sheet if necessary)

	Name	Complete Mailing Address including City, State and Zip	Telephone	E-mail Address
1.				
2.				
3.				
4.				

We/I hereby apply for licensure for the Department of Public Health and Human Services/Child and Family Services Division (DPHHS/CFSD). We/I agree to provide any information required by DPHHS/CFSD to process this application, including interviews, references, physical and/or mental health examinations and health records, if requested. We/I understand that this application does not create any obligation on the part of DPHHS/CFSD to approve us/me as a foster parent(s)/ kinship/adoptive/guardian or to place a child with us/me once I/We are approved. I/We agree that the information provided in this application is true and accurate.

Applicant Signature Date Applicant Signature Date