

Circles of Care

General Application for Potential Providers

If two parent household a separate application needs to be submitted by both parents

Date: _____

PERSONAL INFORMATION:

Name: _____ Date of Birth: ____/____/____

Email: _____

How were you referred or how did you find out about Circles of

Care: _____

Maiden Name: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____ County _____

Home # (____) _____ Work # (____) _____ Other # _____

How long have you lived at the above address? _____

Social Security Number: _____-_____-_____

Tx Drivers License # _____

Marital Status: Married Divorced Separated
 Single Other: _____

Ethnicity: Hispanic African American Caucasian Native
American Other; _____

Religion: Catholic Protestant Jewish Baptist
 Other; _____

If applicable; name of church/ religious institution:

DESCRIPTION OF CURRENT RESIDENCE/HOME ENVIRONMENT:

A. House (Own_____/ Rent_____) Apartment Mobile home
 Duplex

B. Approximate value of residence: \$ _____

C. City Water and Sewer Well and / or Septic Tank

D. Is home equipped with: Central Heat Central Air
 Window Units

E. Does home have any gas used for appliances or water heaters? _____

F. Please List number of: Floors: _____ Bedrooms: _____
Bathrooms: _____

G. Where will the foster child's bedroom be located?

H. Do you have any fire arms or other weapons in the home?
 Yes No

If yes, Please indicate where and how they are stored. (they will be required to be double locked)

I. Do you have any pets in your home or on property? Yes No

If yes, Indicate: Name Age Type

*****Please Note that each pet must have annual Rabies Vaccination for your home to be licensed.*****

Do you have a pool or trampoline? _____

(State standards do no allow trampoline use by foster children due to large number of injuries)

J. Please give directions to your home:

MOTOR VEHICLE INFORMATION:

1) Year _____ Make _____ Model _____

License Plate # _____

2) Year _____ Make _____ Model _____

License Plate # _____

3) Year _____ Make _____ Model _____

License Plate # _____

MEMBERS OF THE HOUSEHOLD: (Include other adults, borders, children, etc.)

Name Relationship DOB Age Sex SS# Occupation

FAMILY MEMBERS NOT LIVING IN THE HOME: (Grown Children) State standards

requires references be sent to adult children or contacted

Name Relationship DOB Age Address Phone #

In Case of Emergency Please Notify:

MEDICAL BACKGROUND:

Please describe all major and minor health problems. _____

Are you or any household members being treated for a physical or psychological illness? Yes No

If yes, please explain: _____

Are you on any medication? Yes No

If yes, Name Amount/how often For

*****Please note that TB tests are required by each family member for your home to be licensed.

CRIMINAL HISTORY:

Have you or your spouse / or any family member living in your home ever been convicted of a misdemeanor or felony? No Yes

If yes, please explain: _____

Have you or your spouse/ or family member living in your home ever been a subject of a report which addresses the serious physical, emotional, sexual abuse or neglect of a child? No Yes

If yes, please explain- Give Dates and circumstances: _____

Have any of your children ever been involved with juvenile court?

No Yes

If yes, please explain: _____

LOCAL AND COMMUNITY RESOURCES:

In what school district do you reside? _____

What school would a foster child attend? Give addresses and phone numbers:

Elementary: _____

Middle/Junior High: _____

High School: _____

Other Spec. School : _____

What medical facilities are located where you live? How far are they?

Please list other community resources in the area (e.g. library, boy/girl scouts, YMCA. Movies, skating):

SPECIAL SKILLS AND INTERESTS:

Foreign Languages: _____ Fluency: _____

Interests and Hobbies: _____

Social Activities you participate in: _____

Professional organizations you belong to: _____

Volunteer work you have done: _____

GENERAL QUESTIONS:

Why do you want to become a foster care provider? _____

What do you feel you and your family can offer a foster child living in your home? _____

Give a brief description of your own childhood, including where you lived, how you were disciplined, how your family communicated, etc.

Has any member of your family been in foster care or provided foster care?

No Yes

If Yes, who, how long?

If you yourself have provided foster care before or are currently foster parents please give information regarding which agencies you were licensed with and the dates you were licensed with them.

How would you handle the financial situation if your foster care reimbursement check failed to arrive when expected/Do you have other reliable income?

What methods of discipline do you think are appropriate for children?

Describe any experience you have in working with children who have emotional, physical, or behavioral problems and what you have learned from that experience:

Have you ever taken anyone into your home for an extended period of time? If so, please explain:

Describe a typical week for you, including what you do in your spare time:

Describe your use of alcohol and /or drugs (i.e. frequency and amount of use):

How do you deal with your frustration and anger towards other people, in particular, children and adolescents:

How do you respond to being supervised by another person?

How do you believe supervision could help you?

How would your lifestyle change with a foster child in your home?

What do you think would make a child:

Run? _____

Hurt him/herself or someone else? _____

Damage Property? _____

Have a tantrum? _____

What could you do to prevent some of the above situations? _____

SUBJECTIVE QUESTIONS:

My family raised me to value:

A. _____

B. _____

C: _____

My three greatest strengths are:

A. _____

B. _____

C: _____

My three greatest weaknesses are:

A. _____

B. _____

C: _____

The worst part of my adolescence was: _____

I expect a child in my care to: _____

I can tell when I am burned out when: _____

I want to learn more about: _____

REFERENCES: **Full names and addresses with zip code must be provided**

Family Member:

| <u>Name</u> | <u>Address</u> | <u>Zip Code</u> | <u>Phone Number</u> |
|-------------|----------------|-----------------|---------------------|
|-------------|----------------|-----------------|---------------------|

Non-Family Member (2)

| <u>Name</u> | <u>Address</u> | <u>Zip Code</u> | <u>Phone Number</u> |
|-------------|----------------|-----------------|---------------------|
|-------------|----------------|-----------------|---------------------|

Employer/Co-worker:

| <u>Name</u> | <u>Address</u> | <u>Zip Code</u> | <u>Phone Number</u> |
|-------------|----------------|-----------------|---------------------|
|-------------|----------------|-----------------|---------------------|

*****Full Address with ZIP CODE must be included*****

CIRCLES OF CARE
BEHAVIOR TOLERANCE CHECKLIST

This sheet is to be completed as part of your licensing procedure. This list will be reviewed with the COC worker and specific areas will be discussed. It will be used in the consideration of future placements. Check the column which best describes your family's reaction to each item and your ability to work with such behaviors and issues. Make additional comments if appropriate. If husband and wife differ in their opinion, they may check different columns and designate "H" for husband and "W" for wife.

| BEHAVIOR | COULD HANDLE | COULD POSSIBLY | WOULD NOT HANDLE | QUALITY, DEGREE, EXTENT, OR ADDITIONAL COMMENTS. |
|---|--------------|----------------|------------------|--|
| DEPRESSION | | | | |
| WITHDRAWL | | | | |
| DESTRUCTION OF PROPERTY | | | | |
| SELF INJURIOUS BEHAVIOR | | | | |
| HYPERACTIVITY | | | | |
| DEFIANCE | | | | |
| VERBAL AGGRESSION | | | | |
| PHYSICAL AGGRESSION | | | | |
| SEVERE PHYSICAL HANDICAP | | | | |
| LEARNING DIFFICULTIES | | | | |
| NERVOUS MANNERISMS | | | | |
| MENTAL RETARDATION | | | | |
| SPEECH IMPEDIMENT | | | | |
| CRYING OR WHINNING | | | | |
| SUICIDAL THOUGHTS | | | | |
| TALKING BACK | | | | |
| POOR HYGIENE HABITS | | | | |
| OVEREATING | | | | |
| ANOREXIA/BULIMIA | | | | |
| RUNNING AWAY | | | | |
| SWEARING | | | | |
| SMOKING (CIGARETTES,ETC.) | | | | |
| FIGHTING | | | | |
| STEALING | | | | |
| ALCOHOL | | | | |
| OTHER DRUG/ CHEMICAL ABUSE | | | | |
| SEXUAL ACTING OUT | | | | |
| MASTERBATION | | | | |
| ENURESIS (BEDWETTING) | | | | |
| ENCOPREIS (UNCONTROLLABLE BOWL MOVEMENTS) | | | | |
| PREGNANCY | | | | |
| TEMPER TANTRUMS | | | | |
| LYING | | | | |

Provider Signature

Date