

Chapter DCF 37

APPENDIX A

**INFORMATION FOR FOSTER PARENTS
FACE SHEET**

Date of Placement: ___ / ___ / ___

Child's Name: _____ Nickname(s): _____ DOB: ___ / ___ / ___ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: ___ - ___ - ___ Cultural Identification (as indicated by child if old enough): _____ Height: _____ Weight: _____ lbs. Religious Preference (of child or family): _____ Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations): _____
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Child's Social Worker With Whom Foster Parent Will Have Contact: Name: _____ Title: _____ Agency: _____ Agency Secondary Contact (if social worker not available): Telephone: Regular Hours: (____) _____ After Hours: (____) _____
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Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s):
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS:
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors?
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a: <input type="checkbox"/> Voluntary Placement <input type="checkbox"/> Court-ordered Placement
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Medical Assistance #:
Insurance Company (if any): Name _____ Telephone: () _____
Policy #: _____ Group #: _____
Physician: _____ Type: _____
Address: _____
Telephone: () _____
Dentist: _____
Address: _____
Telephone: () _____
Other Health Specialists/Therapists
Name: _____ Telephone: () _____ Specialty: _____
Name: _____ Telephone: () _____ Specialty: _____
Preferred Hospital: _____ (Note: Use of hospital may be dictated by insurance company/plan)

Is foster parent expected to participate in therapy with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of	<input type="checkbox"/> Birth Mother:
Child's	<input type="checkbox"/> Stepmother:
(Check most appropriate one)	<input type="checkbox"/> Adoptive mother:
Address:	_____
Telephone: ()	_____
Name of	<input type="checkbox"/> Birth Father:
Child's	<input type="checkbox"/> Stepfather:
(Check most appropriate one)	<input type="checkbox"/> Adoptive father:
Address:	_____
Telephone: ()	_____
Child's Siblings:	
Name: _____	DOB: __/__/__ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Name: _____	DOB: __/__/__ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Name: _____	DOB: __/__/__ Phone: () _____
<input type="checkbox"/> At home	<input type="checkbox"/> Out of home (where: _____)
Significant Extended Family Members (Name, Phone and Relationship):	
Legal Custodian: _____	
Relationship: _____	
Address: _____	Phone: () _____
GAL*/Legal Counsel: _____	
Address: _____	
Telephone: () _____	
*Guardian ad litem	

Significant individuals who may be having contact with the child:			
<u>Name</u>	<u>Phone</u>	<u>Relationship</u>	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Individuals whose contact with the child is forbidden or restricted (e.g., supervised visitation)			
<u>Name</u>	<u>Relationship</u>	<u>Type of Restriction</u>	<u>Rationale (e.g., court order, parents' wishes)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
(Should you have any questions about contacts, please call the child's social worker.)			

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))		
<u>Type (FH, GH, RCC/CCI, hospital, etc.)</u>	<u>Name</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Attending or Will Attend: _____
Telephone: (____) _____ Grade: _____
Is child enrolled in a special education program? ____ Yes ____ No
If yes, what type: _____
Contact Person: _____

Day Care or Respite Provider(s)
_____ Phone: (____) _____
_____ Phone: (____) _____

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)?
Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

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|--|---|--|
| <input type="checkbox"/> Birth certificate (copy),
if available | <input type="checkbox"/> Medical records/summary | * <input type="checkbox"/> Social history/summary |
| * <input type="checkbox"/> Court order | <input type="checkbox"/> Permission to operate
hazardous machines | <input type="checkbox"/> Social Security Card |
| * <input type="checkbox"/> Court report/summary | <input type="checkbox"/> Placement Agreement | * <input type="checkbox"/> Summary of social/
psychiatric evaluations |
| * <input type="checkbox"/> Dental records/summary | * <input type="checkbox"/> School academic
records/summary | |
| <input type="checkbox"/> Information on child's
specific diagnosis and/or
disability | <input type="checkbox"/> School and community
activity permissions | <input type="checkbox"/> Summary of mental
health treatment |
| <input type="checkbox"/> MA card | <input type="checkbox"/> Signed medical release
for emergency health
care | |

* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents. Primary source documents can be provided if useful for clarification.