SECWEPEMC CHILD & FAMILY SERVICES
300 CHILCOTIN ROAD, KAMLOOPS, BC V2H 1G3
PHONE: (250) 314-9669 FAX: (250) 314-9609
www.secwepemcfamilies.ca

APPLICATION TO PROVIDE FOSTER FAMILY CARE

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Child, Family and Community Service Act* (CFCS Act). Under certain circumstances, the collected information may be subject to disclosure as per the CFCS Act and/or the *Freedom of Information* and *Protection of Privacy Act.* Any questions about the collection, use or disclosure of this information should be directed to the Director, Information, Privacy and Records Services Branch, (250) 387-0820, PO Box 9702, Stn Prov Govt, Victoria, B.C. V8W 9S1

INSTRUCTIONS:
If you are filling out this form by hand, please print clearly using ink pen. If you cannot find enough space to include all of your responses to any of the questions on this form, please place on a separate piece of paper and attach it to this application. Once you have completed this form, return it to your Resource Worker.

APPLICANT 1:

FULL NAME:	ALSO KNOWN AS:	DOB: (YYYY/MM/DD)
PLACE OF BIRTH:	ETHNIC ORIGIN:	LANGUAGES SPOKEN:
DO YOU CONSIDER YOURSELF ABORGINAL? ☐ YES ☐ NO	IF YES, IDENTIFY ABORIGINAL CULTURE GROUP/FIRST NATION:	SOCIAL INSURANCE NUMBER

APPLICANT 2:

FULL NAME:	ALSO KNOWN AS:	DOB: (YYYY/MM/DD)
PLACE OF BIRTH:	ETHNIC ORIGIN:	LANGUAGES SPOKEN:
DO YOU CONSIDER YOURSELF ABORGINAL? ☐ YES ☐ NO	IF YES, IDENTIFY ABORIGINAL CULTURE GROUP/FIRST NATION:	SOCIAL INSURANCE NUMBER

ADDRESS & CONTACT INFORMATION:

HOME:	CITY/TOWN:	POSTAL CODE:
MAILING ADDRESS IF DIFFERENT:	CITY/TOWN:	POSTAL CODE:
DIRECTIONS IF NEEDED:	HOME PHONE NUMBER:	CELL PHONE: WORK PHONE:

CHILDREN AND EXTENDED FAMILY MEMBERS:

LAST NAME/FIRST NAME:	GENDER: :	DOB: (YYYY/MM/DD)	RELATIONSHIP:	LOCATION:

Have any of your children ever been placed in foster/family care, treatment or correctional resource?
☐ YES ☐ NO If yes:

SECWEPEMC CHILD & FAMILY SERVICES
300 CHILCOTIN ROAD, KAMLOOPS, BC V2H 1G3
PHONE: (250) 314-9669 FAX: (250) 314-9609
www.secwepemcfamilies.ca

FOSTER/FAMILY CARE:		
WITH WHOM:	WHERE:	DATES: (YYYY/MM/DD:

OTHER RESOURCE:		
NAME:	WHERE:	DATES: (YYYY/MM/DD:

OTHER PERSON(S) IN HOME (e.g. Boarders, daycare children other than own children)

LAST NAME/FIRST NAME:	GENDER: :	DOB: (YYYY/MM/DD)	RELATIONSHIP:	DAYCARE OF RESIDENT:

MARITAL/OTHER RELATIONSHIP:	
LEGAL RELATIONSHIP OF APPLICANTS TO EACH OTHER:	DATE OF MARRIAGE OR LENGTH OF LEGAL RELATIONSHIP:

RELIGION/SPIRITUAL VALUES/BELIEF SYSTEM: (Describe your religion/spiritual values/belief system)	
APPLICANT 1:	APPLICANT 2:

APPLICANT 1	**EDUCATION & EXPERIENCE: (Include date(s) when completed)**	
	EDUCATION COMPLETED:	SPECIAL TRAINING:
	FAMILY/CHILD RELATED COURSES TAKEN:	
	SPECIAL EXPERIENCE RELATED TO FAMILY CARE:	

APPLICANT 2	**EDUCATION & EXPERIENCE: (Include date(s) when completed)**	
	EDUCATION COMPLETED:	SPECIAL TRAINING:
	FAMILY/CHILD RELATED COURSES TAKEN:	
	SPECIAL EXPERIENCE RELATED TO FAMILY CARE:	

APPLICANT 1	**EMPLOYMENT & OCCUPATION:**	APPLICANT 2	**EDUCATION & OCCUPATION:**
	PRESENT EMPLOYER:		**PRESENT EMPLOYER:**
	LENGTH OF PRESENT EMPLOYMENT/OCCUPATION:		**LENGTH OF PRESENT EMPLOYMENT/OCCUPATION:**

SECWEPEMC CHILD & FAMILY SERVICES
300 CHILCOTIN ROAD, KAMLOOPS, BC V2H 1G3
PHONE: (250) 314-9669 FAX: (250) 314-9609
www.secwepemcfamilies.ca

	☐ PART TIME ☐ FULL TIME		☐ PART TIME ☐ FULL TIME
FAMILY APPROXIMATE GROSS YEARLY INCOME:			

CHILD CARE ARRANGEMENTS:
IF APPLICANT(S) IS/ARE WORKING, DESCRIBE CHILD CARE ARRANGEMNETS FOR YOUR PRESCHOOL AND SCHOOL AGE CHILDREN DATE OF MARRIAGE OR LENGTH OF LEGAL RELATIONSHIP:

FAMILY GROUP & INDIVIDUAL INTERESTS, ACTIVITIES, HOBBIES: (Please print)	
1.	5.
2.	6.
3.	7.
4.	8.

HEALTH HISTORY OF APPLICANTS AND HOUSEHOLD MEMBERS:	
Are all family & household members in good health? ☐ YES ☐ NO	
List all members who have treated for serious health illnesses, disabilities, or long term conditions.	
Name:	Condition:
Name	Condition:
Name:	Condition:

MENTAL HEALTH			
List all members who have been seen or counseled for emotional or mental health problems (psychologist, psychiatrist, ministry worker, or mental health clinician)			
Name:	Seen by:	Where:	When:
Name	Seen by:	Where:	When:
Name:	Seen by:	Where:	When:

PHYSICIANS:			
Physician:	Address:	Telephone:	Family member:
Physician:	Address:	Telephone:	Family member:
Physician:	Address:	Telephone:	Family member

APPLICANT 1:	
HAVE YOU EVER APPLIED TO FOSTER CARE BEFORE? ☐ YES ☐ NO	
IF YES, WHERE?	DATES: (YYYY/MM/DD)

SECWEPEMC CHILD & FAMILY SERVICES
300 CHILCOTIN ROAD, KAMLOOPS, BC V2H 1G3
PHONE: (250) 314-9669 FAX: (250) 314-9609
www.secwepemcfamilies.ca

APPLICANT 2:	
HAVE YOU EVER APPLIED TO FOSTER CARE BEFORE? ☐ YES ☐ NO	
IF YES, WHERE?	DATES: (YYYY/MM/DD)

TYPE OF CHILD FOR WHOM YOU COULD PROVIDE CARE:

☐ MALE ☐ FEMALE ☐ BOTH MALE OR FEMALE

ARE YOU OPEN TO TAKING CHILDREN OF A RACIAL/CULTURAL ORIGIN OTHER THAN YOUR OWN? (Please specify)

SIBLING GROUP OF UP TO HOW MANY CHILDREN?

CHILDREN WITH SPECIAL NEEDS: ☐ YES ☐ NO

IF YES, PLEASE INDICATE THE TYPE OF SPECIAL NEEDS YOU CAN PROVIDE CARE FOR:	EXTENT OF SPECIAL NEEDS:
☐ DEVELOPMENTAL ☐BEHAVIORAL ☐ PHYSICAL	☐ MILD ☐ MODERATE ☐ SEVERE

TYPE OF PLACEMENT DESIRED:

☐ EMERGENCY (Up to 30 days) ☐ RESPITE/RELIEF ☐ SHORT TERM (up to 1 year) ☐ LONG TERM (1 year plus)

WHY WOULD YOU LIKE TO PROVIDE CARE TO SOMONE ELSE'S CHILDREN? PLEASE COMMENT

HOME:	
TYPE OF ACCOMODATION (House, apartment, Farm, etc)	

REFERENCES:

NAME:	RELATIONSHIP:	PHONE #:
ADDRESS:	CITY/TOWN:	POSTAL CODE:
NAME	ADDRESS:	PHONE #:
ADDRESS:	CITY/TOWN:	POSTAL CODE:
NAME:	RELATIONSHIP:	PHONE #:
ADDRESS:	CITY/TOWN:	POSTAL CODE:

I DECLARE THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND BELIEVE THAT I HAVE NO OMITTED INFORMATION REQUESTED.

SIGNED:	DATE:		

Please return this form to your Resource Worker