SECWÉPEMC CHILD & FAMILY SERVICES

"Strengthening our Children, Families and Communities"

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 at (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. When complete, please email to resources@secwepemcfamilies.org 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 a 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:
EMAIL ADDRESS:		

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:

PAST INVOLVEMENT WITH ANY CHILD WELFARE AGENCY OUTSIDE OF BRITISH COLUMBIA	
COUNTRY	PROVINCE/STATE

APPROXIMATE TIMELINES

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:

PAST ADDRESSES OUTSIDE OF BRITISH COLUMBIA IN THE LAST TEN YEARS

FULL ADDRESS (UNIT NUMBER, STREET ADDRESS, CITY, PROVINCE/STATE, POSTAL CODE AND COUNTRY)	FROM (YYYY/MM/DD)	TO (YYYY/MM/DD)

INFORMATION REGARDING CHILDREN AND EXTENDED FAMILY MEMBERS

NAME	GENDER (M/F)	BIRTHDATE (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:

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

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

CHILDREN AND EXTENDED FAMILY MEMBERS IN YOUR HOME

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

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:

PRESENT EMPLOYER:

LENGTH OF PRESENT EMPLOYMENT/OCCUPATION:

☐ PART TIME ☐ FULL TIME

APPLICANT 2

EMPLOYMENT & OCCUPATION:

PRESENT EMPLOYER:

LENGTH OF PRESENT EMPLOYMENT/OCCUPATION:

☐ PART TIME ☐ FULL TIME

FAMILY APPROXIMATE GROSS YEARLY INCOME:

CHILD CARE ARRANGEMENTS

IF APPLICANT(S) IS/ARE WORKING, DESCRIBE CHILD CARE ARRANGEMENTS FOR YOUR PRESCHOOL AND SCHOOL AGE CHILDREN

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)

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: ☐ DEVELOPMENTAL ☐ BEHAVIORAL ☐ PHSYCIAL	EXTENT OF SPECIAL NEEDS: ☐ MILD ☐ MODERATE ☐ SEVERE

TYPE OF PLACEMENT DESIRED:			
☐ EMERGENCY (Up to 14 days)	☐ RESPITE/RELIEF	☐ SHORT TERM (up to 1 year)	☐ LONG TERM (1 year plus)
WHY WOULD YOU LIKE TO PROVIDE CARE TO SOMEONE ELSE'S CHILDREN?			
HOME:			
TYPE OF ACCOMODATION (House Apartment, Farm, etc)			

PLEASE PROVIDE 4 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:
NAME:	RELATIONSHIP:	PHONE #:
ADDRESS:	CIRTY/TOWN	POSTAL CODE:

SIGNATURES

I DECLARE THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS COMPLETE AND TRUE TO THEBEST OF MY KNOWLEDGE

_____ _____

Signature Applicant 1 Date

_____ _____

Signature Applicant 2 Date