NIL/TU,O Child and Family Services Society

APPLICATION TO PROVIDE 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 BC, 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.

PART I

APPLICANT #1

FULL NAME	ALSO KNOWN AS (INCLUDING MAIDEN NAME IF APPLICABLE)	DATE OF BIRTH (YYYY/MM/DD)
PLACE OF BIRTH	COMMUNITY OF ORIGIN	LANGUAGES SPOKEN
DO YOU CONSIDER YOURSELF ABORIGINAL? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY YOUR ABORIGINAL CULTURAL GROUP OR FIRST NATION	SOCIAL INSURANCE NUMBER

APPLICANT #2

FULL NAME	ALSO KNOWN AS (INCLUDING MAIDEN NAME IF APPLICABLE)	DATE OF BIRTH (YYYY/MM/DD)
PLACE OF BIRTH	COMMUNITY OF ORIGIN	LANGUAGES SPOKEN
DO YOU CONSIDER YOURSELF ABORIGINAL? ☐ YES ☐ NO	IF YES, PLEASE IDENTIFY YOUR ABORIGINAL CULTURAL GROUP OR FIRST NATION	SOCIAL INSURANCE NUMBER

ADDRESS

HOME ADDRESS	CITY/TOWN	POSTAL CODE
MAILLING ADDRESS (IF DIFFERENT)	CITY/TOWN	POSTAL CODE
DIRECTION TO HOME IF NEEDED		
AREA CODE & HOME PHONE NUMBER	AREA CODE & WORK PHONE (APPLICANT #1)	AREA CODE & WORK PHONE (APPLICANT #2)

INFORMATION REGARDING CHILDREN AND EXTENDED FAMILY MEMBERS CURRENTLY LIVING IN YOUR HOME

NAME	GENDER M/F	BIRTHDATE YYYY/MM/DD	RELATIONSHIP	LOCATION

Have any of your children ever been placed in a family care, treatment or a correctional resource?

☐ YES ☐ NO

FAMILY CARE

WITH WHOM	WHERE	DATE(S) (YYYY/MM/DD)

OTHER RESOURCE

NAME OF RESOURCE	WHERE	DATE(S) (YYYY/MM/DD)

OTHER PERSONS CURRENTLY IN YOUR HOME (e.g. boarders, day care children other than own children)

NAME	GENDER M/F	AGE	RELATIONSHIP	DAY CARE OR RESIDENT

PART II

MARITAL/OTHER RELATIONSHIP

LEGAL REALTIONSHIP 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

EDUCATION AND EXPERIENCE

APPLICANT #1

EDUCATION COMPLETED	SPECIAL TRAINING
FAMILY/CHILD CARE RELATED EXPERIENCE	
SPECIAL EXPERIENCE RELATED TO FAMILY CARE	

APPLICANT #2

EDUCATION COMPLETED	SPECIAL TRAINING
FAMILY/CHILD CARE RELATED EXPERIENCE	
SPECIAL EXPERIENCE RELATED TO FAMILY CARE	

EMPLOYMENT/OCCUPATION

APPLICANT#1		APPLICANT #2	
PRESENT EMPLOYMENT/OCCUPATION		PRESENT EMPLOYMENT/OCCUPATION	
LENGTH OF PRESENT EMPLOYMENT/OCCUPATION	PART TIME/FULL TIME	LENGTH OF PRESENT EMPLOYMENT	PART TIME/FULL TIME

FAMILY'S APPROXIMATE GROSS YEARLY INCOME
$

CHILD CARE ARRANGEMENTS

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

FAMILY GROUP AND INDIVIDUAL INTERESTS, CULTURAL ACTIVITIES, HOBBIES (Please List)

1.	5.
2.	6.
3.	7.
4.	8.

HEALTH HISTORY OF APPLICANTS AND HOUSEHOLD MEMBERS

1. Are all family and household members in good health? ☐ **YES** ☐ **NO**

2. List members who have been treated for serious health illnesses, disabilities, or long term conditions.

NAME	CONDITION
NAME	CONDITION
NAME	CONDITION

3. List members who have been seen or counselled for emotional or mental health problems (by psychologist, psychiatrist, ministry worker, SCCFS worker, any other social worker, or mental health clinic)

NAME	SEEN BY	WHERE	WHEN
NAME	SEEN BY	WHERE	WHEN
NAME	SEEN BY	WHERE	WHEN

4. Doctors used by family (Please list)

DOCTOR'S NAME	ADDRESS	POSTAL CODE	TELEPHONE	FAMILY MEMBER'S NAME
			( )	
			( )	
			( )	

APPLICANT #1

Have you ever applied to become a caregiver before? ☐ **YES** ☐ **NO** **If YES, PLEASE LIST ALL OCCASIONS:**

WHERE	DATE(S) (YYYY/MM/DD)

APPLICANT #2

Have you ever applied to become a caregiver before? ☐ **YES** ☐ **NO** **If YES, PLEASE LIST ALL OCCASIONS:**

WHERE	DATE(S) (YYYY/MM/DD)

TYPE OF CHILD FOR WHOM YOU COULD PROVIDE CARE FOR

☐ Male or Female ☐ Male ☐ Female	AGE RANGE	NUMBER OF CHILDREN

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

Sibling group up to _____ children.

Children with Special Needs: ☐ YES ☐ NO

TYPE OF CHILD FOR WHOM YOU COULD NOT PROVIDE CARE FOR

IF YES, PLEASE INDICATE THE TYPE OF SPECIAL NEEDS YOU CAN PROVIDE FOR:	EXTENT OF SPECIAL NEEDS
☐ Developmental ☐ Behavioural ☐ 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 SOMEONE ELSE'S CHILDREN? PLEASE COMMENT.

HOME

TYPE OF ACCOMODATION (HOUSE, APARTMENT, FARM, ETC.)	PROPOSED SLEEPING ARRANGEMENTS FOR CHILD IF PLACED

PART III

REFERENCES

Please list names and addresses of three persons, including one relative.
These persons must know both of you well enough to answer questions about you and your family.

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
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 NOT OMITTED REQUESTED INFORMATION.

SIGNED	DATE (YYYY/MM/DD)	SIGNED	DATE (YYYY/MM/DD)

Please return this form to your Resource Worker when complete