



Embracing Children.
Inspiring Lives.

GUIDELINES FOR ADOPTION APPLICANTS

- _____ 1. Complete the "Family Demographics Form."
- _____ 2. Complete the "Affidavit of Good Moral Character."
- _____ 3. Provide a Marriage Certificate copy & divorce verification (if applicable).
- _____ 4. Sign the "DCF Release of Information Form."
- _____ 5. Sign the "DCF Confidentiality Agreement" (Keep one copy).
- _____ 6. Read "A Guide to Complaint & Grievance Reporting Procedures."
 Sign the "Complaint Investigation Procedures" receipt.
- _____ 7. Complete "Financial Security Determination." Need 2 years W-2s (or tax returns)
- _____ 8. Not U.S. born, documentation needed: Passport/Green Card/Citizenship Papers
- _____ 9. Complete and sign the "Central Abuse Hotline Record Search."
- _____ 10. Sign the "Local Law Enforcement Check" release (per person age 18 & over).
- _____ 11. Sign Palm Beach County Sheriff's Department release (per person 18 & over).
- _____ 12. Age 12-17, Complete the "Request for FDLE Criminal History Information."
- _____ 13. Age 18 & over, Complete the "Live Scan Information Form."
- _____ 14. Return of Physical Exam & Health Certificate (completed by your Dr.).
- _____ 15. Immediate return of your "References" list.
- _____ 16. Sign the "Acknowledgement of Firearms Safety Requirements."
- _____ 17. Complete the "Auxiliary Aids & Services for the Deaf & Hard of Hearing" form.

Children's Home Society of Florida * 3333 Forest Hill Blvd., West Palm Beach, FL 33406
(561) 868-4300 * Fax (561) 868-4496

Melissa Neeley, MSW
Program Supervisor

Nicole Redford, BA
Adoption Recruiter

Briana Calzada, BSW
Adoption Specialist

Jill Ortiz, BS
Adoption Specialist

Richard Miller, BS
Adoption Specialist

Elizabeth Phelps, BS
Adoption Specialist
MAPP Leader

Christine Hirn, BA
Adoption Specialist

Harriet Zeikowitz, MS, LMHC
Adoption Specialist
MAPP Leader

Date: _____

FAMILY DEMOGRAPHICS FORM - please print legibly

7/2011

Prospective Parent 1

LAST NAME: _____ Maiden Name (if applicable): _____

FIRST NAME: _____ MIDDLE NAME: _____

SSN: _____ DOB _____ GENDER _____

Race: _____ Ethnicity: _____ Religion: _____ Primary Language: _____

Birth City: _____ Birth County: _____ Birth State: _____

Birth Country: _____ Citizenship: _____

Arrest Record - law violations other than minor traffic violations - include expunged and juvenile charges

Where Arrested	Date Arrested	Nature of Charge	Disposition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Circle Your Marital Status: MARRIED SINGLE DIVORCED WIDOWED

List Children of Previous Relationship (s):

Child's Name	Date of Birth	Whereabouts	Support Payments	Describe Contact
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Prospective Parent 2

LAST NAME: _____ Maiden Name (if applicable): _____

FIRST NAME: _____ MIDDLE NAME: _____

SSN: _____ DOB _____ GENDER _____

Race: _____ Ethnicity: _____ Religion: _____ Primary Language: _____

Birth City: _____ Birth County: _____ Birth State: _____

Birth Country: _____ Citizenship: _____

Arrest Record - law violations other than minor traffic violations - include expunged and juvenile charges

Where Arrested	Date Arrested	Nature of Charge	Disposition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Circle Your Marital Status: MARRIED SINGLE DIVORCED WIDOWED

List Children of Previous Relationship (s):

Child's Name	Date of Birth	Whereabouts	Support Payments	Describe Contact
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Primary Address: _____

CITY: _____ STATE: _____ ZIP: _____

Prior Address (if primary is less than 5 years): _____

Prior City: _____ Prior State: _____ Prior Zip: _____

Home Phone: _____ E-Mail(s): _____

Prospective Parent 1 Cell Phone: _____ Prospective Parent 2 Cell Phone: _____

Size of Immediate Family: _____ Annual Family Income: _____

Date of Present Marriage: _____ Attached a copy of your marriage certificate: YES

List Children of Present Relationship:

Child's Name	Child's Date of Birth	Natural or Adopted
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____

Name of Others in your Home:	Date of Birth	Relationship
_____ / _____	_____ / _____	_____ / _____
_____ / _____	_____ / _____	_____ / _____

How did you hear about MAPP Class? _____

Do you know anyone well who is adopted? _____ Relationship: _____

Have you ever applied to adopt a child from another source? _____ When? _____ What source? _____

What child(ren) would you like us to consider for your family (age, sex, siblings, special needs, etc.)?

What child(ren) would you not like us to consider for your family (age, sex, siblings, special needs, etc.)?

Hobbies / Special Interests or Skills / Community Affiliations (Clubs, Lodges, etc.):

Parent 1: _____

Parent 2: _____



AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida

County of: PALM BEACH

Before me this day personally appeared _____
who, being duly sworn, deposes and says:

By signing this form, I am swearing that I have not been found guilty or entered a plea of guilty or nolo contendere (no contest), regardless of the adjudication, to any of the following charges under the provisions of the Florida Statutes or under any similar statute of another jurisdiction. I also attest that I do not have a delinquency record that is similar to any of these offenses.

I understand that I must acknowledge the existence of any criminal records relating to the following list regardless of whether or not those records have been sealed or expunged. I understand that I am also obligated to notify Children's Home Society of any possible disqualifying offenses that may occur while in a position subject to background screening under Chapter 435, Florida Statutes.

- Sections: 415.111 adult abuse, neglect, or exploitation of aged persons or disabled adults
- 741.28 domestic violence and injunction for protection
- 782.04 murder
- 782.07 manslaughter
- 782.071 vehicular homicide
- 782.09 killing of an unborn child by injury to mother
- 784.011 assault, if the victim of the offense was a minor
- 784.021 aggravated assault
- 784.03 battery, if the victim of the offense was a minor
- 784.045 aggravated battery
- 784.075 battery on a detention or commitment facility staff
- 787.01 kidnapping
- 787.02 false imprisonment
- 787.04(2) enticing, removing child from the State or concealing children pending custody hearing
- 787.04(3) carrying child beyond state lines to avoid producing child at custody hearing or to avoid delivering child to designated person
- 790.115(1) exhibiting firearms or weapons within 1,000 feet of a school
- 790.115(2)(b) possessing an electric weapon, destructive device or other weapon on school property
- 794.011 sexual battery
- 794.041 prohibited acts of persons in familial or custodial authority
- Chapter: 796 prostitution
- Section: 798.02 lascivious behavior
- Chapter: 800 lewdness and indecent exposure
- Section: 806.01 arson
- Chapter: 812 felony theft and/or robbery
- Sections: 817.563 fraudulent sale of controlled substances, if the offense was a felony
- 825.102 abuse, aggravated abuse, or neglect of disabled adults or elderly persons
- 825.1025 lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
- 825.103 exploitation of disabled adults or elderly persons, if the offense was a felony
- Sections: 826.04 incest
- 827.03 aggravated child abuse
- 827.04 child abuse
- 827.05 negligent treatment of children
- 827.071 sexual performance by a child
- 827.09 abuse, neglect or exploitation of aged or disabled adults
- 843.01 resisting with violence
- 843.025 depriving an officer means of protection or communication
- 843.12 aiding in an escape
- 843.13 aiding in the escape of juvenile inmate(s)
- Chapter: 847 obscene literature
- Section: 874.05(1) encouraging or recruiting another to join a criminal gang
- Chapter: 893 drug abuse prevention and control only if the offense was a felony or if any other person involved in the offense was a minor

Sections: 944.35(3) inflicting cruel or inhuman treatment on an inmate resulting in bodily harm
944.46 harboring, concealing, or aiding an escaped prisoner
944.47 introduction of contraband into a correctional facility
985.4045 sexual misconduct in juvenile justice programs
985.4046 relating to contraband introduced into detention facilities

ONE OF THE FOLLOWING STATEMENTS MUST BE MADE:

Under the penalty of perjury, which is a first degree misdemeanor, punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding \$1,000.00 pursuant to ss.837.012, or 775.082, or 775.083, Florida Statutes, I attest that I have read the foregoing, and I am eligible to meet the standards of good character for this caretaker position.

Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses

Signature of Affiant

OR

for teachers and non-instructional personnel in lieu of fingerprint submission:

I swear that I have been fingerprinted under Chapter 231, Florida Statutes, when employed as a teacher or non-instructional employee and have not been employed from the school board for more than 90 days. I swear the findings of that background check did not include any of the above offenses and that I meet the standards of good character for this caretaker position.

Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses

Signature of Affiant

Sworn to and subscribed before me

this _____ day of _____, _____.

Personally known

Produced following identification

Notary Public, State of Florida

(Seal)



AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida

County of: PALM BEACH

Before me this day personally appeared _____
who, being duly sworn, deposes and says:

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Signature of Affiant

OR

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Signature of Affiant

Sworn to and subscribed before me

this _____ day of _____, _____.

Personally known

Produced following identification

Notary Public, State of Florida

(Seal)



RELEASE OF INFORMATION

I(we) hereby authorize the release of any information requested by the Department of Children and Families to be utilized in determining my(our) suitability to become

a licensed out-of-home caregiver, or an adoptive parent.

I(we) hereby grant permission to the Department of Children and Families to obtain information from local, state, or federal law enforcement agencies to help determine my(our) suitability to serve as a foster parent or as an adoptive parent. I(we) understand, however, that a history of arrest reported by any of these agencies will not necessarily prohibit my(our) participation in

the licensed out-of-home care program, or the adoption program.

Pursuant to Florida Statute 39.202(2)(a)5., I(we) hereby authorize the Department of Children and Families to make inquiry of the central abuse registry and tracking system in regard to the existence of any confirmed report of abuse, neglect, or exploitation and the results of any investigation pursuant hereto.

Applicant

Date

Applicant

Date

Adult Household Member

Date

Adult Household Member

Date

NOTE: All adult members (age 18 and over) of the household will be responsible for granting consent to these record checks.



CONFIDENTIALITY AGREEMENT

I understand and agree that all information as it relates to child abuse records and clientele are to be held confidential in compliance with the Child Abuse Statute, Florida Statute 39.205 which states "any person who willfully or knowingly makes public or discloses any information contained in the child abuse registry or the records of any child abuse case except as provided in this section is guilty of a misdemeanor of the second degree."

I further agree to treat any such information on clients that should come to my attention and knowledge as privileged and confidential, and that I will not disclose such information to anyone other than authorized persons.

Date

Signature

Witness

Signature

This will acknowledge that I have received a copy of this document.

Date

Signature

Date

Signature



CONFIDENTIALITY AGREEMENT

I understand and agree that all information as it relates to child abuse records and clientele are to be held confidential in compliance with the Child Abuse Statute, Florida Statute 39.205 which states "any person who willfully or knowingly makes public or discloses any information contained in the child abuse registry or the records of any child abuse case except as provided in this section is guilty of a misdemeanor of the second degree."

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Date

Signature

Witness

Signature

This will acknowledge that I have received a copy of this document.

Date

Signature

Date

Signature



A GUIDE TO COMPLAINT & GRIEVANCE REPORTING PROCEDURES

For Consumers of the Department of Children & Families Licensed Adoption Agencies & Child Placing Agencies

Which Child Placing Agencies Must be Licensed by the Dept of Children & Families in District 9?

- * All agencies placing children in foster homes or residential child caring facilities.
- * All adoption agencies located in Palm Beach County.
- * Not attorneys that provide adoption legal services.
- * Not doctors that provide adoption services.
- * Not adoption referral services that recommend adoption resources.

How to Report your Complaint to the Department of Children & Families

We accept your complaints reported by phone. Call 561-837-5078
Or you may address your complaints in writing to :
Department of Children & Families - Client Relations Coordinator
1111 South Sapodilla Ave., West Palm Beach, FL 33401

Complaint Investigation Procedures

1. Licensing staff of the department may make scheduled or unannounced visits to a licensed home, facility or agency at any reasonable time to investigate compliance with the licensing requirements. All agencies shall be inspected at least annually.
2. The department shall investigate complaints to determine if the agency is meeting the licensure requirements.
3. The department shall advise the owner and operator with authority over the licensed agency that there is a licensing complaint when initiating an investigation and shall advise the agency of the results when the investigation is concluded.
4. Whenever the department receives a report questioning the certification status or compliance of a child placing agency with requirements of the state adoption law or alleging violation of this chapter by the agency, the department shall investigate the allegation within 20 working days to determine whether the complaint is substantiated.
5. The department shall notify the complainant and the agency in writing of the results of the complaint investigation within 15 working days after the report of the department's investigation has been finalized.
6. The agency shall fully cooperate with the department whenever such complaint investigations are conducted.

**District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120**



COMPLAINT INVESTIGATION PROCEDURES

By my signature below, I verify that I have received and reviewed "A Guide To Complaint and Grievance Reporting Procedures" for consumers of Florida Department of Children & Families Licensed Adoption Agencies and Child Placing Agencies.

Signature

Date

Signature

Date

Note: The original of this page must be kept on file at the agency.

**District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120**

Working in partnership with local communities to help people be self-sufficient
and live in stable families and communities.

FINANCIAL SECURITY DETERMINATION

	Caregiver 1	Caregiver 2	Household
	Name:	Name:	Combined Monthly Income
Current Employer			\$
Employer's Address			Expenses
			* Housing
Length of Current Employment			* Utilities
Hours & Shifts Worked			* Transportation/Gas
Gross Yearly Salary	\$		* Food / Supplies
Net Take Home	\$ weekly \$ biweekly	\$ weekly \$ biweekly	* Medical
	OR	OR	* Child Care
Medicaid Eligible			* Car Payment
Additional Support or Income			* Car Insurance
* Social Security Benefits			* Credit Cards
* Retirement Benefits			* Other Bills (list below)
* Wages (Temp. Case Assistance)			*
* Disability Benefits			*
* Others (list)			*
*			*
*			*
TOTAL			TOTAL MONTHLY EXPENSES \$

Will child care or after-school care be needed? () Yes () No How will it be provided?

What new expenses are anticipated for the child(ren) to be placed in the home?

Health Insurance Coverage? () Yes () No Name of Insurance Company

\$ of Workman's Compensation Insurance Husband \$ Wife\$ Name of Companies None()

Amount of Life Insurance Husband \$ Wife\$ Name of Companies None()

Please describe any debt or bills that are causing a problem for you at this time.

How would you handle a financial situation if the subsidy check failed to arrive when expected.

Father's Signature _____ Mother's Signature _____ Date _____



Central Abuse Hotline Record Search

I/we, _____ and _____
(please print – first, middle, last name) (please print – spouse first, middle, last name, if applicable)

as an applicant for adoption, an applicant for licensing/registration, or a DCF employee, authorize a search for reports of abuse, neglect or abandonment investigated pursuant to Chapter 39, Florida Statutes in which my name appears and there were "verified indicators" of maltreatment of a child(ren). I understand I will be given the opportunity to discuss the findings of the report(s). I further understand that the central abuse hotline search is only one part of the preliminary report to the court for adoption, one of the requirements reviewed by an agency with the authority to license or approve homes for the care of developmentally disabled persons and children, including family child care homes and facilities, or for DCF employment. This consent is valid solely for the requesting agency/facility listed below on this form.

Applicant Signature: _____ Date: _____ Phone: _____
Print name legibly on line, then affix signature

Spouse Signature: _____ Date: _____ Phone: _____

NOTE: This form must be submitted by one of the agencies identified at the bottom of this page. The applicant/spouse may NOT SUBMIT THIS FORM DIRECTLY to the Department of Children & Families.

Applicant: SSN: _____	DOB: _____	Race: _____	Sex: _____			
Spouse: SSN: _____	DOB: _____	Race: _____	Sex: _____	Prior Name(s): _____		
Current Address:	Address	City	County	State	Zip	Dates at Address
Previous Address:	Address	City	County	State	Zip	Dates at Address
Previous Address:	Address	City	County	State	Zip	Dates at Address

Reason for Record Search: Adoption Applicant (Chapter 63) DCF Employee (Chapter 39)
 Licensing/Registration Applicant (Chapters 39, 415, 402 or 409)

(NOTE: Searches of the Central Abuse Hotline may **not** be used for any employee except those working for DCF.)

Family child care, foster/shelter/group home or adoption applicants must list all child and adult household members on page two of this form. **Do not include any foster care children.**

TO BE COMPLETED BY REQUESTING AGENCY

Child Care Center Family Child Care Home Foster/Shelter/Small Group Home Adoption
 Child-Caring Agency Child-Placing Agency DD Foster/Small Group Home

OCA and/or Facility ID: _____

Facility/Agency Name: _____ Phone: _____

Address: _____
Mailing Address City Zip Code

I understand it is a misdemeanor of the first degree for any agency to use or release abuse, neglect or abandonment information to others. The information is **CONFIDENTIAL** and may be used only for the purpose for which it was obtained.

Printed Name and Signature of Requesting Facility/Agency Representative Date



CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date _____ / _____ / _____

Local Law Enforcement Check

Pursuant to Chapter 85-54, F.S., Children's Home Society of Florida requests a local records check on the applicant listed below, as well as notification of any and all contacts your department has had with this applicant.

LAST NAME FIRST NAME MIDDLE

MAIDEN OR A.K.A

DOB RACE SEX SOCIAL SECURITY #

Please document the findings on this check and return the information to:
Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

Sincerely,

Children's Home Society of Florida

The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

I hereby authorize _____ to check any and all records pertaining to the criminal arrests and convictions, and for any law enforcement agency to release to Children's Home Society of Florida information regarding arrests and convictions and any and all contacts the applicant has had with said agency, under Florida statutes or statutes of any other jurisdiction.

Date _____ / _____ / _____

APPLICANT FOR ADOPTION SIGNATURE



CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date _____ / _____ / _____

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Pursuant to Chapter 85-54, F.S., Children's Home Society of Florida requests a local records check on the applicant listed below, as well as notification of any and all contacts your department has had with this applicant.

LAST NAME	FIRST NAME	MIDDLE
MAIDEN	OR	A.K.A
DOB _____ / _____ / _____	RACE _____	SEX _____
SOCIAL SECURITY # _____		

Please document the findings on this check and return the information to:
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Date _____ / _____ / _____

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DOB / / RACE SEX SOCIAL SECURITY #

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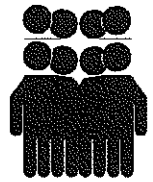
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Date _____ / _____ / _____

APPLICANT FOR ADOPTION SIGNATURE



Please fax to The Foster and Adoptive Parents Association at 352-2544 and call 352-2540 to schedule your appointment. A fingerprint check is requested from adult persons who have not been licensed and thoroughly screened by the Department of Children and Families. This is to safeguard that a child is not left in the care of someone who may have criminal charges found in Florida Statute 435.045 or any other charges, which may indicate a potential risk to a child.

LIVE SCAN INFORMATION FORM

NAME: _____
ALIASES: _____
SS#: _____
DOB: _____
PLACE OF BIRTH: _____
COUNTRY OF CITIZENSHIP: _____
HOME ADDRESS:

CIRCLE ONE: GENDER - M or F

CIRCLE ONE: RACE - A - ASIAN I - NATIVE AMERICAN
 B - BLACK W - CAUCASIAN / LATINO

EYE COLOR: _____ **HEIGHT:** _____

HAIR COLOR: _____ **WEIGHT:** _____

DRIVERS LICENSE # _____

EMPLOYEE NAME AND ADDRESS _____

-----DEPARTMENTAL USE BELOW LINE-----

FACILITY OCA# 09503139Z **REQUEST BY (name)** _____

FACILITY NAME: Childrens Home Society **TELEPHONE #** _____

Date 1st Prints Taken: _____ Prints Taken By: _____

Date Transmitted: _____ Transmit # _____

Date 1st Results Received: _____ Rejected (circle) _____

Check One:

Foster Screening: Foster Parent / Foster Adult / Foster Sitter (circle one)
Adoption Screening: Adoption Parent / Adopt Adult / Adoption Sitter (circle one)



Please fax to The Foster and Adoptive Parents Association at 352-2544 and call 352-2540 to schedule your appointment. A fingerprint check is requested from adult persons who have not been licensed and thoroughly screened by the Department of Children and Families. This is to safeguard that a child is not left in the care of someone who may have criminal charges found in Florida Statute 435.045 or any other charges, which may indicate a potential risk to a child.

LIVE SCAN INFORMATION FORM

NAME: _____
ALIASES: _____
SS#: _____
DOB: _____
PLACE OF BIRTH: _____
COUNTRY OF CITIZENSHIP: _____
HOME ADDRESS:

CIRCLE ONE: GENDER - M or F

CIRCLE ONE: RACE - A - ASIAN I - NATIVE AMERICAN
 B - BLACK W - CAUCASIAN / LATINO

EYE COLOR: _____ **HEIGHT:** _____
HAIR COLOR: _____ **WEIGHT:** _____

DRIVERS LICENSE # _____
EMPLOYEE NAME AND ADDRESS _____

-----DEPARTMENTAL USE BELOW LINE-----

FACILITY OCA# 09503139Z **REQUEST BY (name)** _____

FACILITY NAME: Childrens Home Society **TELEPHONE #** _____

Date 1st Prints Taken: _____ Prints Taken By: _____
 Date Transmitted: _____ Transmit # _____
 Date 1st Results Received: _____ Rejected (circle) _____

Check One:

- Foster Screening: Foster Parent / Foster Adult / Foster Sitter (circle one)**
 Adoption Screening: Adoption Parent / Adopt Adult / Adoption Sitter (circle one)

**THIS FORM MUST BE COMPLETED FOR EACH INDIVIDUAL, AGE 12 THRU 17,
WHO RESIDES IN THE HOME OR WHO IS A FREQUENT, OVERNIGHT VISITOR.**

REQUEST FOR FDLE CRIMINAL HISTORY INFORMATION

DATE: _____

TO: Applicant Section
User Service Bureau
FDLE
Post Office Box 1489
Tallahassee, FL 32302
Attn: Caretaker Program

FACILITY NUMBER: 503139

From: _____
Name of Requester / Children's Home Society of FL

3333 Forest Hill Boulevard
(Mailing Address)

West Palm Beach, Florida 33406

Telephone: (561) 868-4300

The more complete this information is, the better the search and associated results will be.

PLEASE TYPE OR PRINT CLEARLY

Leave this space blank

Applicant Name: _____
Last Name First Name Middle

Other names applicant has used (include maiden names & nicknames)

AKA: _____

Race: (circle one) Black White Asian American Indian
Alaskan Native Unknown

Sex: (circle one) Male Female **Date of Birth:** _____

Social Security Number: _____

Address: _____
Street City State Zip Code

*I certify that the person listed above is a volunteer or a caretaker employee requiring a five-year
rescreening. I understand that the Legislature has established a reduced payment of \$8.00 for the
criminal history checks of these persons.*

(Signature of Owner or On-Site Director)

(Date)

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(Date)



CHILDREN'S HOME SOCIETY

3333 Forest Hill Blvd., West Palm Beach, FL 33406
Phone: 561-868-4300 * Fax: 561-868-4496

ADOPTIVE APPLICANT PHYSICAL EXAMINATION

To Examining Physician: In evaluating the applicant, this agency must be guided by your medical findings as reported on this form. Please print or type all information. Note "N/A" or "None" if applicable. Thank you for your assistance. Please do not leave any blanks.

Applicant's Name: _____ DOB: _____

Address: _____

1. MEDICAL HISTORY: Has the patient ever had:

Table with 4 columns: No, Yes, Year, Outcome. Rows include Tuberculosis, Tumor, Heart Disease, Liver Disease, Neuropathy, Mental Illness, Communicable Disease, Alcoholism, Substance Abuse, Any Genetic Disease, Any Operations.

Type(s) and date(s) _____

II. PHYSICAL EXAMINATION

Date of Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____
Vision: _____ Hearing: _____
Heart: _____ Liver: _____ Lung: _____
Lymph: _____ Thyroid: _____
Nervous System: _____

How long has this person been under your care? _____

What is your assessment of the patient's overall health? _____

Is the patient taking any medications? _____ No _____ Yes If yes, list type of medications taken,

dosage and purpose: _____

Do you know of any physical or mental conditions that will affect the applicant's ability to parent? _____

Please explain: _____

Are you aware of any reason why this patient should not adopt a child? _____

Physician's Signature: _____ Date: _____

M.D. License No: _____ Phone Number: _____

Physician's Name (please print clearly): _____

Address: _____



CHILDREN'S HOME SOCIETY

3333 Forest Hill Blvd., West Palm Beach, FL 33406
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Physician's Name (please print clearly): _____

Address: _____



CHILDREN'S HOME SOCIETY

3333 Forest Hill Blvd., West Palm Beach, FL 33406
Phone: 561-868-4334 * Fax: 561-868-4496

HEALTH CERTIFICATE

Applicant's Name: _____ DOB: _____

Address: _____

The above individual has applied with the Florida Department of Children & Families to be considered as an adoptive parent. The information you provide will help us in considering the applicant through the assessment process. Please feel free to make additional comments.

How long has this person been under your care? _____

Date of last visit? _____

What is the patient's general health and physical condition? _____

Does the individual have any history or evidence of organic or functional disorder? _____

What is the diagnosis? _____ Prognosis? _____

Current medication/dosage/purpose (condition/illness that medications prescribed should be listed under diagnosis)

How would you describe this person's emotional stability? _____

Is this person free from contagious or communicable diseases? _____

Is this person physically and emotionally capable of performing parental responsibilities? _____

Are you aware of any past or current issues of substance abuse, mental health, physiological or surgical services? _____

If so, please describe: _____

Additional comments: _____

Physician's Signature: _____ Date: _____

M.D. License No: _____ Phone Number: _____

Physician's Name (please print clearly): _____



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Are you aware of any past or current issues of substance abuse, mental health, physiological or surgical services? _____

If so, please describe: _____

Additional comments: _____

Physician's Signature: _____ Date : _____

M.D. License No: _____ Phone Number: _____

Physician's Name (please print clearly): _____

REFERENCES

Family Name: _____

1. Relative - Please include either the e-mail or the mailing address.

Name: _____

Phone #: _____

Street: _____

E-Mail: _____

City/State/Zip: _____

2. Personal - Please include either the e-mail or the mailing address.

Name: _____

Phone #: _____

Street: _____

E-Mail: _____

City/State/Zip: _____

3. Personal - Please include either the e-mail or the mailing address.

Name: _____

Phone #: _____

Street: _____

E-Mail: _____

City/State/Zip: _____

4. Employer (wife) - - Please include either the e-mail or the mailing address.

Name: _____

Phone #: _____

Street: _____

E-Mail: _____

City/State/Zip: _____

5. Employer (husband) - - Please include either the e-mail or the mailing address.

Name: _____

Phone #: _____

Street: _____

E-Mail: _____

City/State/Zip: _____



ACKNOWLEDGEMENT OF FIREARMS SAFETY REQUIREMENTS

Florida Statute 790.174 (Safe storage of firearms required) states:

A person who stores or leaves, on a premise under his or her control, a loaded firearm, as defined in s. 790.001, and who knows or reasonably should know that a minor is likely to gain access to the firearm without the lawful permission of the minor's parent or the person having charge of the minor, or without the supervision required by law, shall keep the firearm in a securely locked box or container or in a location which a reasonable person would believe to be secure or shall secure it with a trigger lock, except when the person is carrying the firearm on his or her body or within such close proximity thereto that he or she can retrieve and use it as easily and quickly as if he or she carried it on his or her body.

I/We, _____,
acknowledge that I/we have read and understand this document.

Date

Caregiver Signature

Caregiver Signature

NOTE: This acknowledgement must be executed by all foster and adoptive parents during the home study.

Auxiliary Aids and Services for the Deaf and Hard of Hearing

Screening/Intake/Referral Questions:

1. Are you (the client) disabled?

Yes No

2. Is the client or any of the client's family members/companions who will be involved in receiving services any of the following?

- Deaf or hard-of-hearing ONLY
- Deaf or hard-of-hearing AND visually impaired
- Deaf or hard-of-hearing AND of limited English proficiency
- None of these

3. Do you or any of the client's family members/companions who will be involved in receiving services need any assistance with communication?

Yes No assistance needed No assistance requested (waived assistance)

3.a. If yes to question 3, who needs the assistance?

	<u>Name</u>		<u>Relationship to Client</u>
1.	_____	<input type="checkbox"/>	Consumer <input type="checkbox"/> Companion
2.	_____	<input type="checkbox"/>	Consumer <input type="checkbox"/> Companion
3.	_____	<input type="checkbox"/>	Consumer <input type="checkbox"/> Companion
4.	_____	<input type="checkbox"/>	Consumer <input type="checkbox"/> Companion

3.b. If yes to question 3, in the boxes below, list the number(s) of the individual(s) listed in 3.a. above that indicates the type of assistance that is being requested for each person:

NOTE: Staff are NOT to read this list to clients/companions, but are to use it as a checklist to capture the type of assistance that the client/companion is requesting.

Enter # of individual(s) (from # 3.a. above) that is requesting the assistance

- Sign language interpreter
- Video relay interpreter
- Foreign language interpreter – list language: _____

Enter # of individual(s) (from # 3.a. above) that is requesting the assistance

- Information on CD or floppy diskette
- Information on audiotape
- Information in Braille
- Information in large print
-