1 Care Premier Services

Contract Application

Please complete all information requested. If any item does not apply to you, please write "N/A" so there will not be any delay in the processing of your application.

IDENTIFYING INFORMATION (Please Type or Print Legibly)

Applicant	First Name:	Middle Name:	Last Name:	
Co-Applicant	First Name:	Middle Name:	Last Name:	
Home Address	Street	City	State	Zip
County		Home Phone:		
Applicant Cell:		Co-Applicant Cell:		
Applicant Email Address:		Co-Applicant Email Address:		
Directions to the home from 1 Care Premier Services office:				

Location and Community Resources

School District			
Schools	**Address**	**Phone Number**	**Method of Transportation**
Preschool			☐Walk ☐Bus ☐ FP
Elementary School			☐Walk ☐ Bus ☐ FP
Middle School			☐Walk ☐Bus ☐FP
Junior High School			☐Walk ☐Bus ☐FP

as a family		

MARITAL HISTORY (If you are married, both you and your spouse must apply together)
Current Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed
If married, on what date: _____ How many years have you been married: _____

Applicant's Previous Marriages, if applicable (if more, use a separate page)

Previous Spouse Name	Date of Marriage		How it ended	County & State of Divorce
	From	To	❒ Death ❒ Divorce	
	From	To	❒ Death ❒ Divorce	
	From	To	❒ Death ❒ Divorce	

Co-Applicant's Previous Marriages, if applicable (if more, use a separate page)

Previous Spouse Name	Date of Marriage		How it ended	County & State of Divorce
	From	To	❒ Death ❒ Divorce	
	From	To	❒ Death ❒ Divorce	
	From	To	❒ Death ❒ Divorce	

HOUSEHOLD INFORMATION (Information about *other* people living in your home including foster children, if any)

Full Name (First, Middle, Last)	How Related	DOB	School or Occupation	Social Security Number	If foster child, DFPS Caseworker's Name & Phone

Give the names of all of your children (for both Applicant and Co-Applicant) who live outside your household. Include adult children. According to the *Minimum Standards For Child Placing Agencies*, **all of the children living outside your household, who are 12 years and older, will have to be contacted to complete a child reference.**

Full Name (First, Middle, Last)	How Related	Date of Birth	Phone Number	Address

Frequent Visitors (include all visitors who visit the home more than once per month.)

Name	Relationship	DOB	Phone Number	Address

APPLICANT REFERENCES - Please list the names and addresses of five persons or couples ***not related*** to you who have known you well enough for at least two years to inform us accurately regarding your moral character and life style. At least two of the persons or couples identified must be a member of your community (example: neighbor, church, school, etc.).

Name	How do you know this person	Address	Phone Number	Email Address

One relative reference—this person cannot live in your home.

Name	How do you know this person	Address	Phone Number	Email Address

CO-APPLICANT REFERENCES - Please list the names and addresses of five persons or couples ***not related*** to you who have known you well enough for at least two years to inform us accurately regarding your moral character and life style. At least two of the persons or couples identified must be a member of your community (example: neighbor, church, school, etc.).

Name	How do you know this	Address	Phone Number	Email Address

	person			

One relative reference—this person cannot live in your home.

Name	How do you know this person	Address	Phone Number	Email Address

EMPLOYMENT HISTORY (Show all employment for the last five years; attach additional sheet of paper if needed)
Applicant

Dates of employment	Company name and address	Immediate Supervisor name and phone number	Position held	Reason for leaving position
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				

Co-Applicant

Dates of employment	Company name and address	Immediate Supervisor name and phone number	Position held	Reason for leaving position
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				
Start date: **End date:**				

MEDICAL HISTORY Have you had a history of or treatment for any of the following?

	Applicant	Co-Applicant	Household Member
Are you currently being treated for a physical illness?	❒yes ❒No If yes, please describe:_____	❒yes ❒No If yes, please describe:_____	❒yes ❒No who?_____ If yes, please describe:_____
Are you currently being treated for a mental illness?	❒yes ❒No If yes, please describe:_____	❒yes ❒No If yes, please describe:_____	❒yes ❒No who?_____ If yes, please describe:_____
Do you have a history of mental illness?	❒yes ❒No If yes, please describe:_____ Was treatment provided? ❒yes ❒No If yes, please describe:_____	❒yes ❒No If yes, please describe:_____ Was treatment provided? ❒yes ❒No If yes, please describe:_____	❒yes ❒No who?_____ If yes, please describe:_____ Was treatment provided? ❒yes ❒No If yes, please describe:_____

List all prescription medications being taken on a regular basis:

Medication	Reason for Medication
(circle one)	
App/Co-App/Household Member	
App/Co-App/Household Member	
App/Co-App/Household Member	
App/Co-App/Household Member	
App/Co-App/Household Member	
App/Co-App/Household Member	
App/Co-App/Household Member	

INCOME AND EXPENSES Provide the following information about your financial status.

Monthly Income

Applicant's Income Source: ❑ Employment ❒ Retirement Benefits ❒ Other	Gross yearly $	Net yearly $
Co-Applicant's Income Source: ❑ Employment ❒ Retirement Benefits ❒ Other	$	$
All Other Household Income Source: Rental Income, Alimony, Child Support, Dividends, Adoption Assistance, Foster Care Reimbursement, etc.	$	$
A copy of your most recent 60 days of paycheck stubs and/or other sources of income including Social Security, SNAP, TANF benefits, etc, and consecutive bank statements and/or last year's tax return are required for your file to meet state Minimum Standards.	TOTAL:	$

Assets

Specify Sources (Stocks, Bonds, Savings, Investments, Interest Bearing Accounts, etc.	Value $

Household Expenses: Enter your household's average monthly expenses for the following items. DO NOT INCLUDE EXPENSES THAT ARE DEDUCTED FROM PAYCHECKS.

House/Rent Payments	$	Home or Renter's Insurance, if not included in mortgage	$
Payments for Other Real Property		Automobile Insurance	
Automobile Payments		Life Insurance	

Gasoline and Auto Maintenance		Medical and Dental Insurance, if not taken out of paychecks	
Groceries and Household Supplies		Medical Care (Not covered by insurance)	
Cable		Dental Care (Not covered by insurance)	
Telephone (home and all cells)		Child Support Payments	
Childcare		Utilities (Gas, Water, Electric, Sewer)	
Recreation and Entertainment		Credit Cards	
Loans		Clothing, haircuts, etc.	
Pet Care		Miscellaneous	
Other Debts/Expenses (specify): _____	_____	TOTAL MONTHLY EXPENSES:	$

Please initial next to the following statements to indicate you have read and understand each statement.

____/____ I declare that all statements contained in this application are true and that any misrepresentation or omission is cause for dismissal.

____/____ I also authorize investigations of all statements contained in the application.

____/____ I understand and agree that false statements and/or omissions regarding past conduct and/or present situation may be grounds for denial of the application to provice services and that refusal to inform 1 Care Premier Services of the contents of a criminal record will result in the automatic denial of the application.

____/____ I understand that I must successfully complete Pre-Service Training before I can be licensed as a foster parent and have a client placed with me.

____/____ I understand that I can withdraw from the application process at any time before licensing or approval takes place and that a license will not be granted if I withdraw. I also understand that 1 Care Premier Services can stop the application process at any time before licensing or approval.

____/____ I understand that the information provided in the application will be used to run an OIG check. An OIG (Office of Inspector General) check provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs.

____/____ I understand that 1 Care Premier Services has *ZERO TOLERANCE FOR ABUSE* and takes all allegations of abuse seriously. I further understand that 1 Care Premier Services cooperates fully with the authorities to investigate all cases of alleged abuse. Abuse of clients is grounds for immediate dismissal and possible criminal charges.

____/____ I declare that I am not a pedophile or child molester and that I have not perpetrated physical abuse, sexual abuse, emotional abuse, or neglect against a child or an adult and that I have never been accused of these acts.

____/____ I hereby authorize 1 Care Premier Services to be furnished information regarding my Criminal/Central Registry and other required background records. I also understand that information obtained during the application process and home study may be obtained from other agencies/professionals involved in the home licensing and treatment processes.

____/____ I understand that certain background check results can preclude me from being in the presence of the children served by 1 Care Premier Services. For more information, please refer to the below link: http://dfps.state.tx.us/documents/ChildCare/ChildCareStandarcsandRegulations/Fost_Adopt_Chart.docx

____/____ 1 Care Premier Services hereby certifies that any and all information obtained from the Criminal and/other

needed background information of the above named applicant will be kept in strict confidence and use solely for the purpose of evaluating the household for child placement or evaluation. This consent also authorizes 1 Care Premier Services to submit the individual's Criminal Background check on a yearly basis, so long as the individual is under contract with 1 Care Premier Services, or is affiliated with any of its contractors, sub-contractors, or other employees.

Applicant Signature: _____ **Date:** ____/____/____

Co-Applicant Signature: _____ **Date:** ____/____/____

Please submit this completed application along with a copy of your driver's license and social security card.

I have reviewed this application and have noted any missing information

Agency Representative Signature: _____ **Date:** ____/____/____