

Dear Transfer Foster Parent:

I want to thank you for your interest in transferring to 1 Care Premier Services. My name is Ashley Morales and I am the Foster Home Developer here at the agency. It is my responsibility to ensure that you have a smooth transition between agencies, but that can only be done with your cooperation.

Enclosed is an application packet and other documents needed for this process to go as smoothly as possible.

You will also receive a training packet where you and your respite provider/s are required to complete all 10 trainings.

Thank you again for your interest in helping children and I look forward to working with you.

Sincerely,
Ashley Morales, BSW
Foster Home Developer
1 Care Premier Services, LLC
Texas Licensed Foster and Adoption Agency
340 N. Sam Houston Parkway East Suite A247
Houston, TX 77060
Direct: 832-628-7251

Transfer Foster Parents

- | | |
|--|---|
| <input type="checkbox"/> Release of Information - TRANSFER FAMILIES (signature required) | <input type="checkbox"/> Cleared Statements of Health by M.D. |
| <input type="checkbox"/> Release of Liability - TRANSFER FAMILIES (signature required) | <input type="checkbox"/> Copy of Current Driver's License |
| <input type="checkbox"/> Ethical Family Transfer Process (signature required) | <input type="checkbox"/> Copy of Birth Certificate |
| <input type="checkbox"/> Foster Home Application | <input type="checkbox"/> Copy of Social Security Card |
| <input type="checkbox"/> Foster Parent Reference #1 - Friends/Professional | <input type="checkbox"/> Copy of Auto Insurance |
| <input type="checkbox"/> Foster Parent Reference #2 - Friends/Professional | <input type="checkbox"/> Copy of Homeowners/Renter's Insurance |
| <input type="checkbox"/> Foster Parent Reference #3 - Relative | <input type="checkbox"/> Floor Plan of Foster Home (sq. ft of each room)/Evacuation Route |
| <input type="checkbox"/> Foster Parent Reference #4 - Relative | <input type="checkbox"/> Foster Home Disaster Plan |
| <input type="checkbox"/> Foster Parent Reference #1- Friends/Professional (if applicable) | <input type="checkbox"/> Employment Verification (pay stub) 60 days |
| <input type="checkbox"/> Foster Parent Reference #2 - Friends/Professional (if applicable) | <input type="checkbox"/> W-2 Previous Year or Bank Statement |
| <input type="checkbox"/> Foster Parent Reference #3 - Relative (if applicable) | <input type="checkbox"/> Budget Worksheet |
| <input type="checkbox"/> Foster Parent Reference #4 - Relative (if applicable) | <input type="checkbox"/> Proof of Education (Min: HS diploma or GED) |
| <input type="checkbox"/> Background Check Requirements | <input type="checkbox"/> Marriage License (if applicable) |
| <input type="checkbox"/> Criminal Background Checks on all household members age 14+ | <input type="checkbox"/> Divorce Decree (if applicable) |
| <input type="checkbox"/> Previous CPA Information | <input type="checkbox"/> TB Tests on all household members age 1+ |
| | <input type="checkbox"/> Pet Vaccinations |
| | <input type="checkbox"/> Fire Inspection |
| | <input type="checkbox"/> Health Inspection |
| | <input type="checkbox"/> Gas Inspection (if applicable) |
| | <input type="checkbox"/> Interviews with all Adult Children |

Important Documents

- | | |
|--|--|
| <input type="checkbox"/> Confidentiality-Mandatory Reporting Agreement | <input type="checkbox"/> FP Handbook Acknowledgement |
| <input type="checkbox"/> 40 Hour Observation | <input type="checkbox"/> Foster Home Agreement |
| <input type="checkbox"/> Individualized Training Plan | <input type="checkbox"/> Weapon Inventory |
| <input type="checkbox"/> Foster Home Contractor Manual | <input type="checkbox"/> Motor Vehicle Safety |
| <input type="checkbox"/> Foster Parent Rights | <input type="checkbox"/> Insurance Coverage Policy |
| <input type="checkbox"/> FP Acknowledgement (TX Health Steps, Discipline Policy) | <input type="checkbox"/> HHSC Medical Transportation Information |

APPLICATION PROCESS

1. Release of Information

- This document will only apply to you, if you are a transfer foster parent and would like for us to inform your current agency, you are transferring to us. This allows us to receive all the documents your previous agency has.

2. Release of Liability/Ethical Family Transfer

- These documents state 1 Care Premier did not induce or solicit the transfer foster parent

3. Application

- This application is **9 pages long**
- If you are married, you are required to have a Co-Applicant
- 1 Care Premier Services Office is located at 340 N. Sam Houston Parkway East Suite A247 Houston, TX 77060
- Please fill out to the best of your ability, otherwise it will be sent back.

4. References

- You must have 2 friends/professional **and** 2 relative references
- If you are married, Applicant and Co-Applicant must have different references
- You are responsible for getting these references to us

1 Care Premier Services



AUTHORIZATION TO RELEASE INFORMATION

I (we) _____, hereby expressly authorize the release of any
(Name of Applicant)

and all information in the records of _____ to 1 Care Premier
Services.

(Agency Providing Information)

Please include the following information:

Pre-Service Training and/or PRIDE certificates

CPR and 1st Aid

Psychotropic Medication and/or Medication Administration Certificate & TESTS

Normalcy

EBI

Trauma Informed Care (In Class/Online)

Abuse and Neglect

Medical Consent Certificate

SIDS, Shaken Baby Syndrome, & Early Brain Development

Any CURRENT Training Certificates

Evacuation Route & Floor Plan w/ room dimensions

Health Inspections

Fire Inspections

Pet Vaccinations

Medical Statements from Physician

TB test results for ALL household members

Home screening any addendums or updates

Corrective Action Plans and/or deficiency reports

RCCL investigation findings

Reason for closure or denial of home

References from non-family members

References from adult children

Divorce decrees

Marriage license/certificate

Proof of education

Current auto/home owners insurance

Birth Certificate

Social Security Card and Drivers License

Interior/Exterior Photos

ANY pertinent information on foster children currently in the home

ANY other pertinent information.



Please send this information to:

1 Care Premier Services

Attn:

Address:

Email:

Phone Number:

Fax Number:

Applicant Signature

Date

Applicant Signature

Date

Agency Signature

Date

FOSTER FAMILY RELEASE OF LIABILITY FOR TRANSFERRING TO 1 CARE PREMIER SERVICES

This Release of Liability is executed on this the ____ day of _____, 2022__ by _____ here in after “Foster Family”, and for the protection of “1 Care Premier Services”.

RECITALS

1. Is the Foster Family currently under a contract with another CPA? (Check the correct answer)
 Yes No

2. **If you answered yes, complete the following:** The contract was executed on _____, and expires on or about _____.

3. Did you comply with any and all termination proceedings outlined in your foster parent agreement with your current CPA. (*Example, written 30 day notice.*)
 Yes No

4. Does Foster Family agree that its intent and decision to transfer from its CPA to 1 Care Premier Services was not induced, or otherwise solicited by any staff, volunteers, subcontractors, or affiliated entities of 1 Care Premier Services for the purpose of recruitment or transfer to that Provider agency.
 Yes No

5. The decision to transfer to 1 Care Premier Services is done freely and voluntarily. At no point did 1 Care Premier Services promise you anything to transfer from your current CPA to that Provider agency.
 Yes No

This Release has been read and fully understood by the undersigned and has been explained to me.

Releasor’s Signature: _____

Releasor’s Signature: _____

Print Name: _____

Print Name: _____

Date: _____

Date: _____

Ethical Family Transfer Process

Purpose

- To delineate a transfer process between a family *desiring to transfer* and a family *solicited, enticed, or encouraged to transfer* their verification to another agency. It is important to note that DFPS's primary goal is for all organizations to develop and open additional foster homes to serve children and youth entrusted to our mutual care.
- To facilitate a cooperative spirit between agencies in the DFPS Provider Community.
- To ensure the agency with whom the family is verified receives notification of a transfer request from the family and from the agency contacted; and to provide the agency that verified the family an opportunity to address concerns raised.
- To provide an opportunity for families in good standing with licensing, and those that have started the verification process with a Provider Network organization, to express their concerns and request a verification change, if necessary.
- To prevent the practice of organizations recruiting homes from other organizations within the existing DFPS Contracted Network and to minimize family transfers from one organization to another.

Required practices

- During the term of the contract, no verified family or staff of a DFPS Contractor will be contacted by staff, volunteers, subcontractors, or affiliated entities of another DFPS Contractor for the purpose of recruitment or transfer to that Provider agency. This standard holds even when one organization is planning to close its operations, or is placed on placement hold by Residential Child Care Licensing and wishes to release its homes to other agencies. In these situations, the organization may request that the DFPS Foster Care Redesign Administrator for Regions 2 and 9 send a list of Provider Network organizations with contact information to the affected foster parents, for them to make their own contacts and decision about transferring verification.
- If a verified family contacts another agency for information about a potential transfer, or applies to change verification, the agency contacted will provide the family this *Ethical Family Transfer Process* and direct the family to discuss their concerns with the agency that developed their verification. The contacted agency must also inform the original verifying organization's recruitment or program director by phone and by email, within five (5) business days of contact, regarding the date of the family's contact for a request to transfer (with a cc to the DFPS Foster Care Redesign Administrator for Regions 2 and 9).
- The contacted agency may have no further contact with the family for at least 30 days, or until they have received a release and closing summary from the verification organization,

whichever is sooner, to allow sufficient time for that organization to meet with the family to resolve any outstanding issues that may be present.

If the family still wishes to make a transfer, the originating organization will transfer verification information to the agency with whom the family wishes to transfer, with a closing summary and release form signed by an administrator of the organization, no later than thirty (30) days after having received notification (with a cc to the DFPS Foster Care Redesign Administrator for Regions 2 and 9).

DFPS encourages foster families and organizations to contact the DFPS Foster Care Redesign Administrator if families are solicited directly or indirectly *in an unethical manner* to make a transfer to another organization.

The DFPS Foster Care Redesign Administrator will review all organizations' recruitment plans and patterns in quarterly and annual reviews. Contractor agrees to provide this information to DFPS and also agrees to allow DFPS to disclose this information with the Provider Council at regular meetings.

____/____ I declare that a 1 Care Premier Services representative reviewed the Ethical Family Transfer Process with me.

____/____ I declare that at no point was I contacted by staff, volunteers, subcontractors, or affiliated entities of 1 Care Premier Services for the purpose of recruitment or transfer to that Provider agency.

____/____ I declare that the decision to transfer to 1 Care Premier Services was done freely and voluntarily.

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

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

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



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			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
Elementary School			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
Middle School			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
Junior High School			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
High School			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP

Community Locations	Address	Phone	Method of Transportation
Nearest Hospital:			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
Nearest Park:			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP
Nearest Library:			<input type="checkbox"/> Walk <input type="checkbox"/> Bus <input type="checkbox"/> FP

Do you attend a church? yes no

Name of Church	
Denomination	
Address of Church	
Name of Pastor	
Pastor's Phone Number	

Have you applied to another Child or Adult Placing Agency in the past? yes No

If yes, please list ALL agencies to which you have applied (both Applicant and Co-Applicant)

Date of application	Company name and address	Company number	Was a home study completed?

Why do you want to become a foster parent?

What kind of child(ren) are you interested in caring for (how many, age, gender, etc)?

How and when did you hear about 1 Care Premier Services?

Home Information	<input type="checkbox"/> Own <input type="checkbox"/> Rent	
Do you have weapons in your home? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____	Do you have a pool or hot tub? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____	Do you have a trampoline? <input type="checkbox"/> yes <input type="checkbox"/> No

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How long at current address? _____ years If less than 10, list previous address(es) where you lived in the last 10 years:

From _____ To _____
 From _____ To _____
 From _____ To _____
 From _____ To _____

Please provide the following personal information:

	Applicant (Primary Caregiver)	Co-Applicant (Secondary Caregiver)
Social Security Number		
Date of Birth		
Driver's license State & Number	State: _____ Number: _____	State: _____ Number: _____
Place of Birth (City, State)		
Citizenship (what country)		
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Race	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander
Any names previously used (maiden, different first or last name)		
Education-highest grade or degree completed		
Language(s) spoken		
Military Service	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> N/A Branch: _____ Dates _____ of Service: _____ Type _____ of Discharge: _____	<input type="checkbox"/> current <input type="checkbox"/> past <input type="checkbox"/> N/A Branch: _____ Dates of Service: _____ Type _____ of Discharge: _____
Have you ever been convicted of any crime?	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____
Have you ever been accused of physical abuse, emotional abuse, sexual abuse or neglect of a child or adult?	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____
List organizations or groups you belong to		
List any volunteer work you do		
Describe any church or religious affiliations you have		
Describe any interests and activities you enjoy alone or 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	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> 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	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> Divorce	
			<input type="checkbox"/> Death	<input type="checkbox"/> 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 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

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?	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No who? _____ If yes, please describe: _____ _____
Are you currently being treated for a mental illness?	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No who? _____ If yes, please describe: _____ _____
Do you have a history of mental illness?	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____ Was treatment provided? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____ Was treatment provided? <input type="checkbox"/> yes <input type="checkbox"/> No If yes, please describe: _____ _____	<input type="checkbox"/> yes <input type="checkbox"/> No who? _____ If yes, please describe: _____ _____ Was treatment provided? <input type="checkbox"/> yes <input type="checkbox"/> 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	Gross yearly	Net yearly
Source: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement Benefits <input type="checkbox"/> Other	\$	\$
Co-Applicant's Income		
Source: <input type="checkbox"/> Employment <input type="checkbox"/> Retirement Benefits <input type="checkbox"/> Other	\$	\$
All Other Household Income Source: Rental Income, Alimony, Child Support, Dividends, Adoption Assistance, Foster Care Reimbursement, etc.	\$	\$
<i>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.</i>		\$
	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 provide 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/ChildCareStandardsandRegulations/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:** ____/____/____

3. Please comment on the applicant's sensitivity to the needs of others.

4. How do you feel this applicant does in stressful situations? Please explain.

5. Does the applicant participate in any hobbies or recreational pursuits regularly? What are they?

6. Please comment on the quality of the applicant's home life, i.e., general atmosphere.

7. If the applicant is married, is the marriage stable? Are the children well adjusted?

8. Would you be comfortable placing one of your own children with the applicant?

9. Are you aware of any reason why 1 Care Premier Services should not place an individual in the applicant's home?

10. Please provide any additional comments, which would help us determine the eligibility of the applicant.

Reference's Signature

____/____/____
Date

If applicable:
Interviewed by: _____
Date: _____

Please email or fax information to:
1 Care Premier Services
340 N. Sam Houston PKWY E. Suite 247
Houston TX, 77060
Fax: 713-583-0900
nicole.mays@1careps.com

BACKGROUND

1. Background Check Requirements

- This is a detailed list on who **requires** a background check.
- Please read carefully and circle appropriately on the Background Consent Form

2. Background Consent Form

- Having read Background Check Requirements, please provide all the Background Consent Forms needed.

Foster Parent(s) Name: _____

Background Check Requirements

The following definitions of persons requiring background checks have been developed in accordance with DFPS Minimum Standards sections, §745.601, §745.615, and 1 Care Premier Services Policies & Procedures. Please refer to the following definitions to determine who requires a background check, and initial beside each statement confirming that you have read and understand the requirements.

Household Members

___ Any person who resides in the home 14 and over requires a background check.

Regular Visitor

___ A person is considered a regular visitor if they are 14 and over and are at your home on a scheduled basis (i.e. every third weekend of the month, or every Tuesday and Wednesday of the week).

Frequent Visitor

___ A person is considered a frequent visitor if they are 14 and over are in your home for more than two non-continuous visits in a 30-day period;

___ One continuous stay at your home per year and the duration of the stay exceeds seven days; OR

___ More than two continuous stays at your home per year and the duration of each exceeds 48 hours.

___ A frequent visitor will require a background check if they are 14 and over and reside in the Foster Parent's home overnight at any time.

Family Members

___ Any family member will require a background check if they meet the definition of a frequent, regular, or overnight visitor as listed above.

___ The following family members living within 150 miles of the Foster Parent's home will require a background check, regardless of their status as a visitor:

- The Foster Parent's parents or step-parents
- The Foster Parent's siblings and their spouses
- The Foster Parent's children, 14 and over, who live outside of the home

Individuals Requiring FBI Checks

___ All household members 14 and over.

___ All regular or frequent visitors to the home who have lived out of state within the last 5 years.

___ All overnight visitors to the home.

___ All family members who have lived out of state within the last 5 years.

___ All babysitters and respite providers.

FOSTER HOME NAME:

1 Care Premier Services



**CONSENT TO OBTAIN
REQUEST FOR CRIMINAL BACKGROUND CHECK**

NAME: (as appears on drivers' license)

First Name: _____ Middle Name: _____ Last Name: _____

Name Suffix: (If any-circle) 2nd, 3rd, 4th, 5th, Jr., Sr., MD, PhD, Other _____

S.S. # _____ ID type (Circle one): None Driver's license State issued ID ID # _____

ID State: _____ D.O.B. _____ Gender (Circle one): Male Female

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip Code: _____ County: _____ Home Phone #: _____

Relationship to the Requester: (Circle one) Foster parent Adoptive parent Caregiver Household member Volunteer

Family Friend (other Staff) Relative of Foster parent (other staff) Frequent Visitor (other Staff) Employee (Staff)

Babysitter (other staff)

Other cities of residence in Texas: _____

Have you lived anywhere other than TEXAS in the last 5 years? _____

If yes list all previous address (es) including the County: _____

Ethnicity: _____ Hispanic _____ Non-Hispanic _____ Unable to Determine

Race: _____ American Indian/Alaskan Native _____ Asian _____ Black _____ White _____ Native Hawaiian /Pacific Islander
_____ Unable to Determine

List all maiden and/or alternative names:

First Name: _____ Middle: _____ Maiden or Last Name: _____ Name Suffix: _____

➤ I, _____, the person identified above, 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. If my role is a frequent visitor, I understand I cannot frequent a foster home until my background checks have been cleared by the agency. I further understand that this is a non-expiring consent; withdrawal of this consent must be in writing.

➤ Applicant understands that certain background check results can preclude you from being in the presence of the children we serve. For more information please refer to the below link:
[http:// dfps.state.tx.us/documents/Child Care/Child Care Standards and Regulations/Fost_Adopt_Chart.docx](http://dfps.state.tx.us/documents/Child_Care/Child_Care_Standards_and_Regulations/Fost_Adopt_Chart.docx).

Applicant Signature

Date

1 Care Premier Services Staff Signature

Date

FOSTER HOME NAME:

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.

OTHER DOCUMENTATIONS

1. Statement of Health

- Please give this form to your doctor confirming you are in a good state of health

2. Foster Family Budget Worksheet

- Fill this out to the best of your ability

3. Weapons Inventory

- This document asks whether there is weapons in the home

4. Disaster Plan

- You must have a plan in case any disasters happen, report how this will happen in this plan

1 Care Premier Services



Statement of Health

MEDICAL

Is the foster parent currently free of communicable diseases?	Yes/No	If No, explain.
Does the foster parent have a history of chronic physical or mental illness?	Yes/No	If yes, explain.
In your opinion, is the foster parent physically and emotionally capable of accepting added responsibility of providing care and guidance to individuals with emotional and/or behavior problems or other special needs?	Yes/No	If No, explain.

MEDICATIONS

Is the foster parent required to take any medication?	Yes/No	If so, please indicate name of medication, dosage and for what medical symptom or problem:
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Date of last doctor's visit and reason:

Has the foster parent ever been treated for alcohol or substance abuse? No ____ Yes ____

If yes, when and where?

Signature of Physician

Date

Physician Address: _____

Physician Phone Number: _____



FOSTER FAMILY BUDGET WORKSHEET

	MONTHLY INCOMES
Foster Father Job:	
Foster Mother Job:	
Child Support:	
Investment Interest Payments:	
Inheritance:	
Other:	
TOTAL INCOME:	
	MONTHLY EXPENSES
Mortgages/Rent:	
Utilities:	
Car Fuel:	
Groceries:	
Extracurricular Activities: Music Lessons, Teen Sports, School Expenses	
Family Outings: Movies, Going Out to Eat	
Grooming: Hair, Nails, Cosmetic, Clothing	
Household Necessities: Toilet paper, Cleaning supplies	
Gym Membership:	
Church Tithes:	
Retirement and Savings:	
Medical Insurance/Co-Pays/Medical Bills:	
Credit Card Payments:	
Car Payments:	
Fees:	
Tolls:	

Babysitting Costs:	
Insurance: Car and House :	
College Tuition/College Loans:	
Pets:	
Other/Miscellaneous:	
TOTAL EXPENSES:	

Foster Parent Signature

Date

Staff Signature

Date

1 Care Premier Services



Weapons Inventory

(Foster Family)

Weapons and ammunition must be stored and locked separately.
Please refer to the foster parent handbook for the complete weapons policy.

List of Weapons

Describe Storage of Weapons

Describe Storage of Ammunition

List of Weapons	Describe Storage of Weapons	Describe Storage of Ammunition

There are no weapons of any kind nor any ammunition stored anywhere in my home or on my property.

This is a complete listing of all the weapons currently stored in my home/on my property. I understand that I should notify my Clinical Coordinator of any additional weapons acquired or stored on the premises of my home in the future. I also understand I must review the safety issue of weapons and conduct an inventory of weapons with any respite provider I use with foster children.

Foster Parent(s) Signature

Date



DISASTER PLAN FOR DFPS FOSTER AND ADOPTIVE HOMES

Purpose: This form is used to record the emergency and disaster plan that the foster and adoptive families create in the event of an emergency or disaster.

Instructions: DFPS staff provides this form to the family to complete. When the family has completed the form, DFPS staff enters the information in IMPACT and files the paper version in the case file.

HOME INFORMATION		
Home Name:	Name of Caregiver #1:	Name of Caregiver #2:
Residence Address:	County:	
Mailing Address (if different):	School District:	
Home Phone:	Mobile Phone Caregiver #1:	Mobile Phone Caregiver #2:
Email Address:		

DIRECTIONS TO THE HOME
DFPS has developed this document to ensure that foster and adoptive families: 1) have a plan for and can be located in the event of an emergency or disaster; 2) have information on disaster preparedness; and 3) understand the CPS disaster policy. Please answer the following questions so that you can be found in the event of an emergency and so that DFPS is aware of who you have identified for emergency caregiving if you are unable to continue providing care during an emergency or disaster situation. Please notify your caseworker if there are any changes to this plan. A copy of this form will be provided to you after you complete it.



EMERGENCY CONTACTS AND CAREGIVERS

Please designate two people who do not live with you and whom you will call to tell them of your location and contact information in the event you must evacuate your home. If you cannot be located after an emergency, DFPS will contact them.

Contact #1	Contact #2
Name:	Name:
Address (Street, City, State, Zip):	Address (Street, City, State, Zip):
Home Phone Number:	Home Phone Number:
Mobile/Secondary Phone Number:	Mobile/Secondary Phone Number:

Please designate two people whom you will call for emergency babysitting/caregiving services. Emergency babysitters/caregivers must be approved by FAD staff and the child’s caseworker before services are needed. Per Minimum Standards, alternative caregiving services (babysitting) cannot exceed 72 hours. Emergency childcare exceeding 72 hours must be facilitated by FAD staff for respite services.

Contact #1	Contact #2
Name:	Name:
Address (Street, City, State, Zip):	Address (Street, City, State, Zip):
Home Phone Number:	Home Phone Number:
Mobile/Secondary Phone Number:	Mobile/Secondary Phone Number:

CPS DISASTER POLICY

If a disaster or emergency situation is declared, you must follow any orders implemented in response to the declaration for the area in which you live.

You must evacuate if an evacuation is mandated (required) for the area in which you live. Once you reach your evacuation destination, you are required to contact DFPS as soon as possible. If the local CPS office is closed, you may call the DFPS Hotline (1-800-252-5400) to make the required notification. In the event of a major disaster, the DFPS public website (www.dfps.state.tx.us) will post information about how to contact DFPS and the status of local office closures. In some situations, DFPS will send you a Send Word Now (SWN) text message to verify your safety and to assess immediate needs.

If DFPS cannot reach you following an evacuation, disaster, or other emergency situation, they will contact the emergency contacts listed on this form.



MY PLAN FOR DISASTERS THAT OCCUR WITHOUT WARNING

1. In the event an emergency occurs without warning that prevents me from returning to my home (for example, fire, flash flooding, act of terrorism), I (we) plan to (check one):

Stay with family/friends

Names:

Addresses:

Phone:

Stay in a hotel

Other, describe:

2. What is your alternate plan?

Describe:



MY PLAN FOR DISASTERS THAT OCCUR WITH WARNING

1. What I (we) will do if an evacuation is not required

a. In the event there is a warning that a potential disaster such as a hurricane or tornado could head toward my (our) residence, but officials do not mandate (require) that people evacuate, I (we) plan to (check one):

Evacuate

To a family/friend's home:

Names:

Addresses:

Phone:

To a hotel

To a shelter

Other, describe:

b. What is your alternate plan? Describe:

2. What I (we) will do if an evacuation is required

a. If an evacuation for my area were mandated (required), I (we) would go (check one):

Evacuate

To a family/friend's home:

Names:

Addresses:

Phone:

To a hotel

To a shelter

Other, describe:

3. Who would provide transportation for you to evacuate (check one)?

Self

Other (Name and Phone Number):



4. Is there anyone in your home who would require special attention during an evacuation (check one)?

Yes

• Name(s):

• Type of attention needed:

• How will children who are younger than 24 months of age be evacuated and relocated to a designated safe area or alternate shelter?

• How will children who have limited mobility or who otherwise may need assistance in an emergency, be evacuated and relocated to a designated safe area or alternate shelter?

• How will you ensure that the medications or medical equipment will be available to children?

No

Please make additional comments here:

PROTOCOL FOR SERIOUS ILLNESS, INJURY, AND OTHER EMERGENCIES

1. Notify your DFPS FAD Caseworker immediately

- If anyone residing in your foster home becomes ill with a serious or highly contagious illness, or is suspected of having contracted a pandemic illness; or
- Of other events which may affect your capacity to care for the children.

2. Continue to update DFPS with significant changes to your health and the children's health as well as that of anyone who is approved to care for the children



BASIC DISASTER AND EMERGENCY PREPARATION INFORMATION

Examples of emergency situations and disasters are numerous and can include a single house fire or a hurricane that destroys cities. They can occur without warning and at any time of year, so it is important for everyone in the home to be prepared at all times.

If you must evacuate your home, make sure that you have all necessary contact information and supplies that will be needed while you are gone. Evacuations can last less than a day or for an unknown period of time.

You should take, at a minimum, the following items:

- at least a two-week supply of medication in its container (if applicable);
- other medical supplies and equipment (such as first aid kit, glasses, face masks, gloves, etc.);
- important paperwork (such as placement and medical authorizations and the educational portfolio and Medicaid card for each child);
- this form; and
- contact information for your caseworker and his or her supervisor.

Even if the emergency situation does not require evacuation, you should make sure you have the above items readily available.

You should always have enough emergency supplies to last your family at least one week. Examples of necessary supplies are non-perishable and canned food, water, medicine, first aid supplies, batteries, flashlights, diapers, and a battery-powered radio.

You should also have information on local emergency services (addresses and telephone numbers) written down in a secure place.

More information on preparing for a disaster can be located online at the Red Cross’s disaster preparedness website, www.redcross.org/prepare.

Call 2-1-1 to find out information about shelters as well as emergency and disaster related-related services.

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our [Privacy and Security Policy](#).

SIGNATURES

Signing this form indicates that I have read and understand the CPS Disaster Policy.

Caregiver #1: X	Date Signed:
Caregiver #2: X	Date Signed:
Caseworker Name and Phone Number:	Supervisor Name and Phone Number:

Please attach a copy of the following documents:

- Current Driver's License
- Social Security Card
- Homeowner/Renter's Insurance
- Auto Insurance
- Proof of Education
- Marriage License
- Divorce Decree (if applicable)
- Floor Plan of Foster Home (sq. ft of each room)
- Employment Verification (pay stub) **60 days**
- W-2 Previous Year **OR** Bank Statement
- TB Test
- Fire Inspection
- Health Inspection
- Gas Inspection