RESOURCES FOR FOSTER FAMILY INITIAL LICENSING APPLICATION AND CHECKLIST

Licensing Specialist/Family Service Coordinator: ______________________________

Resource Foster Family: ____________________________

DIRECTIONS: Please submit new licensing packets to your worker in the following order. This checklist must be completed prior to submitting completed packet to designated worker. DO NOT FAX to Licensing or DCF.

☐ Request for KBI/DCF Child Abuse Registry Check for Family Foster Homes (CCL 002).

☐ Licensed/Approved Family Foster Home Application (CCL 401). Must be completed and signed/dated by all parties including Child Placing Agency staff.

☐ Floor Plan- including specific dimensions of all rooms, ceiling heights, location and dimension of windows, and who will be living in which room.

☐ Foster Family Financial Assessment

☐ Direct Deposit Form

☐ Policy Statement on Discipline- to be signed/dated by each parent in the home.

☐ KVC Foster Care Provider Requirements- to be read, reviewed, and signed/dated by each parent and CPA staff.

☐ Confidentiality or Non-Disclosure- one form to be signed/dated by each foster parent.

☐ File Review Form

☐ Family Foster Home Sample Menu (CCL 404)

☐ Yearly Mechanical Safety Check (CCL 005). Family must complete a form for each vehicle used to transport children. To be kept on file in the home or in the vehicle. (2 per packet). *You can complete this yourself; it does not need to be done by a mechanic.

☐ Certificate of Health Assessment (CCL 009). Must have one completed for each adult and adolescent over the age of 16 years. (2 per packet).

☐ Certificate of Health Assessment for Foster Care Provider's Own Children (CCL 059). Must have one completed on each child living in the home under age 16, does not include foster children.

☐ Pet/Animal Approval form. Must have the signature of the veterinary that regularly sees the pet.

☐ Recruitment—Personal Information Data Base Form

☐ KVC Foster Parent Mentoring Acknowledgement Form

☐ KVC Foster Parent Information Sheet

NOTE: Check to be sure that you send copies of immunization records for pets in your home.

KVC CPA
Revised 8/30/16
REQUEST FOR KBI/DCF CHILD ABUSE REGISTRY CHECK FOR RESIDENTIAL CARE FACILITIES, FFHs and CPAs

Directions: COMPLETE BOTH SIDES OF THIS FORM. All blank pages must be completed; however, social security number is optional. Incomplete forms will be returned. If a person does not have a Maiden or other name, write N/A. DO NOT include children or youth for whom you provide services. K.A.R. 28-4-125(c) requires the facility to keep a copy of the completed form on file.

Type of Facility: 
- [ ] 24 Hour Residential Care Including Family Foster Care  
- [ ] Child Placement Agency

<table>
<thead>
<tr>
<th>Name of Facility exactly AS STATED ON THE LICENSE</th>
<th>License #</th>
<th>Date (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address of Facility</td>
<td>City</td>
<td>Zip Code + 4</td>
</tr>
<tr>
<td>First and Last Name of the Individual Completing This Form</td>
<td>Phone #</td>
<td>E-mail address</td>
</tr>
</tbody>
</table>

I. This request for background check is being completed to meet the requirements (CHECK ONLY ONE of the THREE OPTIONS BELOW):
- [ ] Initial Application (New Facility, Move, or Change of Ownership)
- [ ] Renewal Application
- [ ] Adding a New person(s) living, working or volunteering in the facility. The information provided on this form is to include only the identifying information for new individual(s).

II. Check YES or NO for each question below with regard to the persons listed on this form. If YES, complete the information in this section. The information provided on this form is to include: yourself, all other persons 10 years of age and older living in the facility and all persons working and/or volunteering in the facility; all substitutes and other caregivers and staff including relief and support staff.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Name of Person</th>
<th>Date</th>
<th>Court of Action State and County</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>Had a misdemeanor or felony conviction of a crime against persons, a sexual offense or crimes affecting family relationships and children?</td>
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<tr>
<td></td>
<td></td>
<td>Had a felony conviction under the uniform controlled substances act?</td>
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<td>Been adjudicated (found or determined in a court of law to be) a juvenile offender, delinquent, or miscreant?</td>
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<td></td>
<td>Committed physical, mental or emotional abuse or neglect or sexual abuse as validated by DCF or any other state or governmental agency, regardless if such validation has been expunged?</td>
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<tr>
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<td>Had a child declared in a court order to be deprived or in need of care based on allegation of physical, mental or emotional abuse or neglect or sexual abuse?</td>
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<td>Had parental rights terminated?</td>
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<td>Signed a diversion agreement involving child abuse or a sexual offense?</td>
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<td></td>
<td>Been found to be a disabled person in need of a guardian or conservator or both?</td>
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</table>
FAMILY FOSTER HOME APPLICATION FOR LICENSURE, APPROVAL OR RENEWAL

Strong Families Make a Strong Kansas. The service you offer to children and youth is important to the community and will have a lasting impact on the children/youth in your home. It is also important to their families. Kansas child care laws and regulations are designed to reduce the predictable risks of harm to children and youth. By completing and submitting this application you are: 1) requesting a license to operate a family foster home and 2) affirming that you have read and agree to comply with all laws and regulations for family foster homes in Kansas.

SECTION I. APPLICANT INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

<table>
<thead>
<tr>
<th>Applicant's Legal Name</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Work # ( )</th>
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</thead>
<tbody>
<tr>
<td>Spouse/Co-Applicant Legal Name</td>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Cell # ( )</td>
</tr>
<tr>
<td>Physical Address of Home (Street Address)</td>
<td>City</td>
<td>Zip Code +4</td>
<td></td>
<td></td>
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<tr>
<td>County</td>
<td>Phone Number ( )</td>
<td>Email Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing Address of the Home (if different than above)</td>
<td>City</td>
<td>Zip Code +4</td>
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</tbody>
</table>

This home is connected to: [ ] Public Water [ ] Public Sewer [ ] Well Water * [ ] Septic Tank/Lagoon *

*If not on public water/sewer, annual approval of water supply and sewage disposal is required.

SECTION II. INTENT OF THE APPLICANT/OPERATOR. COMPLETE ONE OF THE TWO BOXES BELOW (NEW OR RENEWAL).

- [ ] This application is for a new family foster home.
- [ ] This application is for a family foster home that is currently licensed or approved, but we are:
  - [ ] Moving to a new location
  - [ ] Changing ownership (example: adding or removing someone from the license)
  - [ ]Changing our program type (example: from an approved home to a licensed home)

- [ ] This application is for:
  - [ ] A license
  - [ ] An approval for age (16+)
  - [ ] An approval for relative care
  - [ ] An approval for a military base
  - [ ] An approval for an Indian Reservation

Number __________ and ages __________ of children for whom we wish to provide care.

If we have applied for, have, or had a license, approval from KDHE or DCF:

- [ ] NO
- [ ] YES

If yes, specify the following: Date applied for __________

Type of care __________ Year __________ License # __________

Name and address if different from current:

| Name | Street Address | City | State | Zip | County |

RENEWAL APPLICATION

- [ ] This application is notification to renew my/our existing license for another year.
SECTION III. REFERENCE INFORMATION. INITIAL APPLICANTS ONLY. PLEASE LIST THREE REFERENCES IN ADDITION TO EMPLOYERS AND LIMITED TO NO MORE THAN ONE RELATIVE. ADDITIONAL REFERENCES MAY BE REQUESTED.

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<tr>
<th>Name</th>
<th>Street Address</th>
<th>City, State, Zip Code</th>
<th>Telephone Number</th>
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SECTION IV. ANNUAL TRAINING FOR RENEWAL APPLICATIONS AND NEW APPLICATIONS DUE TO A MOVE, PROGRAM CHANGE, OR OWNERSHIP CHANGE. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

K.A.R. 28-4-806 requires foster parents to provide evidence of child care experience and knowledge of child care methods which will enable any child to develop his or her potential. K.A.R. 28-4-806(b) requires each foster parent to have at least eight clock-hours of training in specific topic areas each licensing year, of which at least 2 clock-hours are obtained through participation in group training.

APPLICANT NAME:

<table>
<thead>
<tr>
<th>TRAINING TITLE</th>
<th>TOPIC AREA</th>
<th>PRESENTER</th>
<th>DATE OF TRAINING</th>
<th>HOURS</th>
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APPLICANT NAME:

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<th>TRAINING TITLE</th>
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<th>DATE OF TRAINING</th>
<th>HOURS</th>
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SECTION VII. MAILING INSTRUCTIONS. SUBMIT THE DOCUMENTS LISTED IN ONE OF THE TWO BOXES BELOW (INITIAL/NEW APPLICATION OR RENEWAL APPLICATION), AS APPLICABLE. FOLLOW THE MAILING INSTRUCTIONS PROVIDED.

NEW APPLICATION

Submit only the following documents to DCF:
- Completed and signed application (FCL 401) (signed by the applicant(s) and sponsoring child placing agency licensing worker).
- KBI/DCF Background Check Request form (FCL 002) [You must keep a copy on file]
- Fingerprint-based Check of Criminal History/Out of State Child Abuse/Neglect Registry form (FCL 411) and fingerprint/registry results (if available at time of application)*
- Recommendation For Use by CPA & Intent to Place (FCL 653)
- A complete floor plan of your home giving linear measurements for each room. Include fire escape routes and room layout of each floor. Identify how each room is used and specify who will use each bedroom. Designate all window and door locations. Provide measurements of each window in bedrooms or rooms which may be potential bedrooms. If the basement is used as living space, show second exit which goes directly to the outside and provide the dimensions.
- Attach directions to the home if in a rural location or if the home may be difficult to locate.
- The Licensed & Approved Family Foster Home Survey form (FCL 403) and the original Notice of Survey Finding form (FCL 657)
- Copy of PS-MAPP or PS-Deciding Together certificate for each foster parent applicant [You must keep a copy on file]
- Copy of First Aid (3 hours, face-to-face) certificate for each foster parent applicant* [You must keep a copy on file]
- Copy of Medication Administration certificate for each foster parent applicant* [You must keep a copy on file]
- Copy of Universal Precautions certificate for each foster parent applicant* (You must keep a copy on file)

YOU WILL WORK WITH YOUR SPONSORING CHILD PLACING AGENCY TO ENSURE THAT THE FORMS/DOCUMENTS LISTED ABOVE ARE INCLUDED IN YOUR APPLICATION PACKET TO BE SUBMITTED TO DCF. IT IS RECOMMENDED YOU KEEP A COPY OF ALL SUBMITTED MATERIALS. BE SURE TO KEEP ORIGINALS OF YOUR TRAINING CERTIFICATES.

*If fingerprint results have not been obtained or first aid, medication administration and/or universal precautions training has not been taken at time of application, results and/or certificates need to be forwarded to DCF upon completion.

RENEWAL APPLICATION

Submit only the following documents to DCF:
- Completed and signed application (FCL 401) (signed by the licensee(s) and sponsoring child placing agency licensing worker).
- KBI/DCF Background Check Request form (FCL 002) [You must keep a copy on file]
- Continued Recommendation for Use by CPA (FCL 654)
- Training report for each foster parent, including at least 8 clock-hours of training annually [You must keep a copy on file]
- The Licensed & Approved Family Foster Home Survey form (FCL 403) and the original Notice of Survey Finding form (FCL 657)

YOU WILL WORK WITH YOUR SPONSORING CHILD PLACING AGENCY TO ENSURE THAT THE FORMS/DOCUMENTS LISTED ABOVE ARE INCLUDED IN YOUR ANNUAL RENEWAL APPLICATION PACKET TO BE SUBMITTED TO DCF. IT IS RECOMMENDED THAT YOU KEEP A COPY OF ALL SUBMITTED MATERIALS. BE SURE TO KEEP YOUR TRAINING CERTIFICATES. IF SOME OF YOUR TRAINING HOURS ARE FROM BOOK OR VIDEO REPORTS, KEEP A COPY OF THE APPROVED REPORTS IN YOUR FILE (APPROVED REPORTS WILL BE SIGNED BY THE SPONSORING CHILD PLACING AGENCY LICENSING WORKER TO INDICATE ACCEPTANCE). DO NOT SEND COPIES OF TRAINING CERTIFICATES FOR RENEWALS TO DCF UNLESS REQUESTED.

NOTE: WITHOUT SPECIFIC INSTRUCTION FROM DCF, DO NOT SEND IN THE FOLLOWING: Health Assessments; TB/Chest X-ray reports; Provider checklists; Documentation of pet immunizations; menus; and/or vehicle inspections.
FAMILY FOSTER HOME
FLOOR PLAN

NAME: ________________________________

Please draw a floor plan for each level of your house. Give Information including: room sizes (Length and width), window sizes (Length and width of opening), floor to opening of window measurements and ceiling heights. Each floor will need to be on a separate piece of paper. Label each room (master bedroom, bedroom #2, bedroom #3, bathroom, kitchen, dining room etc.). Add the name or identity of each person who will sleep in each bedroom. Please note which bedroom will be used by foster children. Be sure to show the doors and windows, and if below ground, show the second exit to the outside for a safe fire exit.

Which Floor? _________________________

--This form may be photocopied--
## FOSTER FAMILY BUDGET

### APPLICANT #1

<table>
<thead>
<tr>
<th>Name</th>
<th>*Current Employment</th>
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<table>
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<tr>
<th>*Gross Monthly Income</th>
<th>*Net Income</th>
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</table>

*Other Sources of Income/Resources:

<table>
<thead>
<tr>
<th>Source</th>
<th>Monthly Net Income:</th>
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Total Monthly Net Income: 

### APPLICANT #2

<table>
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<tr>
<th>Name</th>
<th>*Current Employment</th>
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<tr>
<th>*Gross Monthly Income</th>
<th>*Net Income</th>
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*Other Sources of Income/Resources:

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<tr>
<th>Source</th>
<th>Monthly Net Income:</th>
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Total Monthly Net Income: 

## EXPENSES

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<thead>
<tr>
<th>Expense</th>
<th>Monthly Amount</th>
<th>Fixed or Estimated Amount?</th>
</tr>
</thead>
<tbody>
<tr>
<td>House Payment or Rent</td>
<td></td>
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<tr>
<td>Medical</td>
<td></td>
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<tr>
<td>Groceries</td>
<td></td>
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<tr>
<td>Child Care</td>
<td></td>
<td></td>
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<tr>
<td>Car Payments</td>
<td></td>
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<tr>
<td>Credit Card Payments</td>
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<tr>
<td>Utilities (gas, electricity, water, phone, trash, etc.)</td>
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<tr>
<td>Clothing</td>
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<tr>
<td>Entertainment</td>
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<tr>
<td>Other (use as many spaces as needed)</td>
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</tr>
<tr>
<td><strong>Total Monthly Expenses</strong></td>
<td></td>
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</table>
Total Monthly Income/Resources $___________

Total Monthly Expenses: $___________

Difference (positive or negative amount) $___________

Number of adults in the home: __________________________

Number of children in the home: __________________________
(For renewals, please indicate how many children in the home are foster children.)

Please retain this form and give it to the DCF surveyor at the time of your initial inspection OR to your sponsoring agency licensing worker at the time of renewal.

FAMILY FINANCES CAN BE COMPLICATED AND THIS IS A SUMMARY FORM ONLY. PLEASE FEEL FREE TO ATTACH A SHORT EXPLANATORY STATEMENT IF YOU FEEL IT WILL ASSIST IN UNDERSTANDING YOUR FINANCIAL SITUATION.

*Please provide documentation for income of all types. Documentation will only be reviewed. It will not be taken from the foster parents nor maintained by the Division.

__________________________________________
Foster Parent signature Date Foster Parent Signature Date

__________________________________________
DCF Surveyor Date CPA Staff Date

Kansas Department for Children and Families
Strong Families Make a Strong Kansas
Authorization Agreement for Direct Deposit – Kansas Foster

**WE OFFER DIRECT DEPOSIT TO YOUR PREPAID CARD**

Please read this form carefully and write legibly.

A. Bank Name: ________________________________________________
B. Bank Routing #: ____________________________________________
C. Bank Account #: ____________________________________________

Account Type: □ Checking   -or-   □ Savings

- I authorize Bank of Blue Valley to deposit my net pay into the above listed account.
- I understand that by providing my email address below that I am authorizing KVC to email me copies of my remittance advice and that no further copies will be mailed.

PLEASE ATTACH A VOIDED CHECK HERE

If a check is not available, please attach a letter from your bank on their letterhead listing your account information.

Applicant Signature: __________________________________________ Email Address: ______________________________

Name (printed): _____________________________________________ Date: ______________________________

Please return to KVC Accounting Department:

- Mail: 21350 W 153rd St., Olathe, KS 66061
- Email: accountspayable@kvc.org
- Fax: 913-322-3523

Revised 3/14/2017
CONFIDENTIALITY OR NON-DISCLOSURE

All KVC personnel, subcontractors, and volunteers are responsible for maintaining the confidentiality of information relating to KVC client(s), client families, staff persons(s), or program business. The general expectation that personnel or subcontractors will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent. In all cases what is disclosed will be the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

Confidential care and treatment includes refraining from identifying a foster child as such in any internet communications with others, including social networking sites. Posting pictures of a child or information identifying a child as a foster child on the internet violates confidentiality requirements.

By my signature below, I attest that I have read and understand the Confidentiality or Non-disclosure agreement and will abide by it.

Signature

Date
KVC Behavioral HealthCare

POLICY STATEMENT ON DISCIPLINE

Discipline is an essential part of child rearing and when used positively it contributes to the healthy growth and development of a child and establishes positive patterns of behavior in preparation for adulthood. The object of discipline is to promote behaviors that are beneficial to the child’s development and welfare and to change and/or eliminate behaviors that are injurious to his or her well being. Therefore, we encourage positive discipline as a most important aspect of child rearing services and care.

Positive discipline, when used for purposes of guiding and teaching the child, provides the child encouragement, a sense of satisfaction, and helps the child understand the consequences of his/her behavior. Effective positive discipline provides behavioral limits on the child that can provide the child a sense of security, engender a respect for order, and enable the child to predict and understand his/her surroundings. This type of discipline effectively enlists the child’s help rather than locking the child and adult into a power struggle or adversarial, punishing relationships and promotes the child’s discovery of those values that will be of the greatest benefit to the child, both now and in the future.

There are laws, which protect adults against actions, which many children must endure and suffer under the guise of discipline. Many children who are in care have previously suffered too much physical pain, fear, humiliation, and emotional stress. We cannot perpetuate this when we assure the positive roles in our child rearing practices of which positive discipline is an essential part.

Therefore, KVC does not view as positive, acceptable discipline any action administered in a fashion which may cause any child to suffer physical or emotional damage. Disciplinary acts which cause pain, such as hitting, beatings, shakings, cursing, threatening, binding, closeting, prolonged isolation, denial of meals, and derogatory remarks about the child or his/her family are not acceptable.

While the foregoing statement is not all-inclusive in terms of unacceptable forms of discipline, it does provide a guide for the establishment of the following statement of policy:

IT SHALL BE THE POLICY KVC THAT NO FOSTER PARENT USE DISCIPLINARY ACTS WHICH CAUSE PAIN, SUCH AS HITTING, BEATING, SHAKING, CURSING, THREATENING, BINDING, CLOSETING, PROLONGED ISOLATION, DENIAL OF MEALS, AND DEROGATORY REMARKS ABOUT THE CHILD OR HIS OR HER FAMILY.

By signing this document, I hereby acknowledge that I have read the policy statement and understand that by using disciplinary acts which are disapproved of MAY RESULT IN CLOSURE OF MY FOSTER HOME.

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FOSTER FAMILY PROVIDER REQUIREMENTS

GENERAL REQUIREMENTS:

- I agree to complete required pre-service training (PS-MAPP or Deciding Together & First Aid) and license with the Kansas Department of Health & Environment, prior to accepting a foster/adoptive child into care.
- I agree to accept placements ONLY as approved through KVC Admissions and KVC’s CPA and will utilize the provided list of questions regarding child’s behaviors to determine appropriateness of placement for my home.
- I agree to provide KVC at least 14 calendar days notice when asking for removal of child unless the child is in imminent danger to themselves or others (as defined by admission to a psychiatric or detention facility. Child must meet screening guidelines). I will assist KVC in transitioning child to another placement. I agree to provide 30 calendar days notice when asking for the removal of a child who has been in my home for six months or longer.
- I agree to complete the required annual in-service training and provide documentation of training to KVC Family Service Coordinator (FSC).

For two parent households:

- 16 hours per family for Satellite Foster Care, Step, and/or Emergency Foster Care
- 24 hours per family for Diversion Foster Care, Intensive Foster Care, or SFL

(Each parent must complete a minimum of 8 hours of the total required for the family. Two of the 8 hours must include face to face training.)

For single parent households:

- 8 hours for Satellite Foster Care, Step, and/or Emergency Foster Care
- 12 hours per family for Diversion Foster Care, Intensive Foster Care, or SFL

(Two of the 8 hours must include face to face training)

CHILD AND FAMILY:

- I will respect the right of confidentiality relating to information regarding the foster child or his/her family. The right of confidentiality includes refraining from identifying a foster child as such in any internet communications with others, including social networking sites. I will not post photos of the children on the internet or any social networking site.
- I will strive to maintain an objective, positive attitude and understanding toward the birth parents and other family members of the child in care.
- I agree to incorporate the child into the family affording him/her the same privileges and responsibilities as other family members, appropriate to his/her age and abilities.
- I agree to preserve and maintain all personal possessions and documented records of the child and relinquish said belongings, including those acquired while in our care, upon their leaving our home.
- I will notify KVC FSC of any changes or impending changes in family/household composition including, but not limited to moving, new persons living in the home, marriage, death, divorce, adoption, or serious illness.
- I understand that KVC strongly suggests that we maintain appropriate renter’s, homeowner’s, household and car insurance to cover physical damages that might occur as a result of a child being placed in our home. Although KVC maintains professional liability insurance for negligence involving licensed foster parents, this insurance does not cover such loses.
DAY-TO-DAY DUTIES:
- I agree to comply with all DCF licensing standards and regulations.
- I understand that KVC or DCF may make unannounced visits to my home at any time and request to walk through my home to ensure compliance with all laws and licensing regulations.
- I will act as substitute parents by transporting child in care to school, medical/dental appointments, mental health appointments, work, visits, case plans, court and activities. I understand that transportation by foster parents is required for all transportation, including family visits, up to 30 miles in each direction. If over 30 miles in each direction, transportation through the KVC Transportation Department may be arranged.
- I will participate actively to facilitate the development and implementation of the child’s Case Plan.
- I agree to obtain needed/prescribed medical, dental, psychiatric care including KAN-BE-HEALTHY medical screenings when appropriate, and maintain current medical records on appropriate forms in the home and provide copies to KVC FSC, along with other necessary records.
- For a school-aged child, I will work on the child’s behalf to facilitate a smooth enrollment process and ongoing communication with the schools. I will work with the schools to obtain free textbooks and school lunches when applicable.
- I will obtain DCF’s permission, through KVC, prior to taking the child out of state or moving to another residence.

RESPITE:
- If I provide short-term respite care, I understand that my license may be exceeded by a maximum of 2 additional children in foster care or a sibling group of any size.
- I agree to adhere to DCF licensing laws and regulations when providing short-term respite care.
- I understand that short-term respite care is conducted for a child in foster care for less than 24 hours per week (each week begins at 12:01am on Sunday).
- I understand that my Family Service coordinator must pre-approve any short-term respite care that I provide.
- I agree to notify my Family Service Coordinator of my intent to provide short-term respite prior to providing the care.

☐ This family is approved to provide short-term respite
☐ This family is approved for respite care not to exceed license capacity

__________________________________________  ______________________________
Family Service Coordinator                                     Date

I understand that any violation of these requirements may result in removal of the child from my home, withdrawal of sponsorship of foster care license, or other corrective action measures.

I have read and understand this agreement. KVC staff reviewed each of the requirements and answered any and all questions to my satisfaction.

__________________________________________  ______________________________
Foster Parent                                      Date

__________________________________________  ______________________________
Foster Parent                                      Date

__________________________________________  ______________________________
Agency Representative                               Date

REV 5/15
CONFIDENTIALITY OR NON-DISCLOSURE

All KVC personnel, subcontractors, and volunteers are responsible for maintaining the confidentiality of information relating to KVC client(s), client families, staff persons(s), or program business. The general expectation that personnel or subcontractors will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person or when laws or regulations require disclosure without a client's consent. In all cases what is disclosed will be the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

Confidential care and treatment includes refraining from identifying a foster child as such in any internet communications with others, including social networking sites. Posting pictures of a child or information identifying a child as a foster child on the internet violates confidentiality requirements.

By my signature below, I attest that I have read and understand the Confidentiality or Non-disclosure agreement and will abide by it.
KVC Behavioral HealthCare, Inc. provides Family Preservation, Reintegration, Foster Care and Adoption services to children and families referred by the Department for Children and Families.

By becoming a placement provider for a child served by KVC, information gathered throughout the licensing and placement processes, in addition to information accumulated throughout the placement period, could be reviewed for quality assurance by the Department for Children and Families, Kansas Department of Health and Environment, and/or an accrediting organization, such as The Joint Commission.

The KVC employee working with your family will inform you if your file has been randomly selected for review. KVC understands that during the licensing and placement processes, personal and sensitive information is required to be supplied to the agency. Only those members of the auditing team will be allowed access to this sensitive information. If there are persons you do not wish to have access to your file, please list those persons below and include your relationship to each individual listed.

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP TO PLACEMENT</th>
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<tbody>
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</tbody>
</table>

By signing below, I am indicating that I have reviewed the information above. I understand my personal information will only be reviewed by those individuals given the authority to review my file for the purpose of quality assurance. I also understand that a representative from KVC will inform me when my file is selected for review and which organization has been asked to review it. If I feel as though my personal information has been provided to persons other than those authorized, I will request information from the KVC representative in order to file a complaint within the agency.

________________________________________
Signature

Date

________________________________________
Signature

Date
FAMILY FOSTER HOME SAMPLE MENU

Please complete the sample menu chart by inserting menus for one week's meals as if the children were eating every meal at the foster home. Complete only on initial application. Keep the completed menu page in your files. The surveyor/licensing social worker will review the menu page during your survey or assessment.

<table>
<thead>
<tr>
<th>Day</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>AM Snack</td>
<td></td>
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<tr>
<td>Lunch</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PM Snack</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
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</tr>
</tbody>
</table>

Applicant/Licensee Signature    Date    Applicant/Licensee Signature    Date
YEARLY MECHANICAL SAFETY CHECK
FOR VEHICLES USED TO TRANSPORT CHILDREN IN A DCF-LICENSED FACILITY

Facility Name Exactly as it Appears on the License

License Number

Street Address

City

County

Complete a form for each vehicle used to transport children. A record of the check and corrections shall be kept on file at the facility or in the vehicle.

In accordance with K.A.R. 28-4-130(a)(2)(B), a yearly mechanical safety check has been completed on the items listed for the vehicle identified on this form:

- Tires
- Make of car: ____________________________
- Year: ______
- Lights
- Number of individual restraints: ________________
- Windshield wipers
- Vehicle Insurance Policy No: _______________________
- Horn
- Suspension
- In accordance with K.A.R. 28-4-130(a)(3), liability limits are:
- Signal lights
- Brakes
- Personal injury or death in any one accident: ____________
- Steering
- Personal injury or death to two or more persons in any one accident: ________________
- Suspension
- Exhaust system
- Loss of property: _______________________
- Outside mirror

The safety check was completed by ____________________________ on ________________________ (MM/DD/YYYY).

In accordance with 28-4-130(a)(4)(B), a first aid kit is also required in vehicles transporting children. The first aid kit is in the vehicle and contains the following:

- Bandages (all sizes)
- 1 pkg. 4"x4" gauze squares
- Adhesive tape
- Cleansing agent (green soap, pump soap antiseptic ointment or spray is acceptable
- Roll of gauze
- Scissors
- 1 elastic bandage
- Disposable non-porous gloves

I attest that this information is true and correct.

Signature for Facility ____________________________ Date (MM/DD/YYYY)
YEARLY MECHANICAL SAFETY CHECK
FOR VEHICLES USED TO TRANSPORT CHILDREN IN A DCF-LICENSED FACILITY

Facility Name Exactly as it Appears on the License ___________________________

License Number ___________________________

Street Address ___________________________ City ___________________________

County ___________________________

Complete a form for each vehicle used to transport children. A record of the check and corrections shall be kept on file at the facility or in the vehicle.

In accordance with K.A.R. 28-4-130(a)(2)(B), a yearly mechanical safety check has been completed on the items listed for the vehicle identified on this form:

☐ Tires
☐ Lights
☐ Windshield wipers
☐ Horn
☐ Signal lights
☐ Steering
☐ Suspension
☐ Glass
☐ Brakes
☐ Tail lights
☐ Exhaust system
☐ Outside mirror

Make of car: ___________________________ Year: ______

Number of individual restraints: ___________________________

Vehicle Insurance Policy No: ___________________________

In accordance with K.A.R. 28-4-130(a)(3), liability limits are:

Personal injury or death in any one accident: ___________________________

Personal injury or death to two or more persons in any one accident: ___________________________

Loss of property: ___________________________

The safety check was completed by ___________________________ on ___________________________

First ___________________________ Last ___________________________ (MM/DD/YYYY)

In accordance with 28-4-130(a)(4)(B), a first aid kit is also required in vehicles transporting children. The first aid kit is in the vehicle and contains the following:

• Bandages (all sizes)
• 1 pkg. 4"x4" gauze squares
• Adhesive tape
• Cleansing agent (green soap, pump soap antiseptic ointment or spray is acceptable
• Roll of gauze
• Scissors
• 1 elastic bandage
• Disposable non-porous gloves

I attest that this information is true and correct.

Signature for Facility ___________________________ Date (MM/DD/YYYY)
CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Name of the facility (exactly as stated on the license)

License #

Street Address

City

Zip Code

County

Check type of child care facility:

☐ Attendant Care Facility

☐ Detention Center

☐ Family Foster Home

☐ Group Boarding Home

☐ Staff Secure Facility

☐ Residential Center

☐ Secure Residential Treatment Facility

☐ Secure Care Center

Name of Foster Parent/Staff

(First)

(Middle)

(Last)

Date of Birth

(MM/DD/YYYY)

Please check each question. If answer is yes, please explain. Yes No

1. Do you see a physician regularly for any health condition?

2. Are you taking any medication regularly?

3. Have you had any surgery in the past 3 years?

4. Do you have any handicapping conditions which might interfere with the care of children?

5. Do you have any chronic illness conditions such as:

   Headaches

   Heart Disease

   High Blood Pressure

   Lung Disease

   Cancer

   Diabetes

   Convulsions

   Mental Illness

   Alcoholism

   Arthritis

   Liver Disease

   Other

If Other, Describe: ________________________________________________________________

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. I do not find evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

   Signature of Licensed Physician or Nurse trained to perform health assessments.

   Date (MM/DD/YYYY)

2. I found evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

   Signature of Licensed Physician or Nurse trained to perform health assessments.

   Date (MM/DD/YYYY)

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on ___________________________ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by ____________________________ Licensed Physician/Nurse Signature or Health Department

Date (MM/DD/YYYY)
CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

**TO BE COMPLETED BY PROVIDER/STAFF (Please print)**

<table>
<thead>
<tr>
<th>Name of the facility (exactly as stated on the license)</th>
<th>License #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Check type of child care facility:
- [ ] Attendant Care Facility
- [ ] Detention Center
- [ ] Family Foster Home
- [ ] Group Boarding Home
- [ ] Staff Secure Facility
- [ ] Residential Center
- [ ] Secure Residential Treatment Facility
- [ ] Secure Care Center

<table>
<thead>
<tr>
<th>Name of Foster Parent/Staff</th>
<th>(First)</th>
<th>(Middle)</th>
<th>(Last)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
</tr>
</thead>
</table>

Please check each question. If answer is yes, please explain.

1. Do you see a physician regularly for any health condition? Yes ☐ No ☐
2. Are you taking any medication regularly? Yes ☐ No ☐
3. Have you had any surgery in the past 3 years? Yes ☐ No ☐
4. Do you have any handicapping conditions which might interfere with the care of children? Yes ☐ No ☐
5. Do you have any chronic illness conditions such as:
   - [ ] Headaches
   - [ ] Heart Disease
   - [ ] High Blood Pressure
   - [ ] Lung Disease
   - [ ] Cancer
   - [ ] Diabetes
   - [ ] Convulsions
   - [ ] Mental Illness
   - [ ] Alcoholism
   - [ ] Arthritis
   - [ ] Liver Disease
   - [ ] Other
   - [ ] If Other, Describe: __________________________

**TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:**

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

   Signature of Licensed Physician or Nurse trained to perform health assessments. __________________________

   Date (MM/DD/YYYY) __________________________

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

   Signature of Licensed Physician or Nurse trained to perform health assessments. __________________________

   Date (MM/DD/YYYY) __________________________

Record results of TB test or attach results to this form.

Negative tuberculin test □ or negative chest x-ray □ on __________________________ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by __________________________ Date (MM/DD/YYYY) __________________________
CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Complete this section of the form for each child under age 16 residing in the foster home, excluding foster children.

Child's Name __________________________________________ Date of Birth _______ Sex _______

Parent(s) Name(s) ______________________________________

Address ____________________________ Street _______ City _______ Zip Code _______

Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY. Update this for each time immunizations are given.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPT, DT*, TD (*DT only if child is allergic to DTP)</td>
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<tr>
<td>POJO</td>
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<tr>
<td>MMR</td>
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</tr>
<tr>
<td>RUBEOLA (MEASLES)</td>
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<tr>
<td>MUMPS</td>
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</tr>
<tr>
<td>RUBELLA (GERMAN MEASLE)</td>
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</tr>
<tr>
<td>Hb (Hemophilus Inf. B) *RECOMMENDED</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>HBV (Hepatitis B Vaccine) *RECOMMENDED</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>VAR (Varicella-Chicken Pox) *RECOMMENDED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This section is to be completed and signed by a nurse approved by DCF to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES ____________________________

CURRENT MEDICATIONS ____________________________

NUTRITIONAL STATUS ____________________________

HEIGHT ____________________________

WEIGHT ____________________________

PHYSICAL EXAMINATION

HEAD ____________________________

ABDOMEN ____________________________

EENT ____________________________

GU ____________________________

TEETH ____________________________

GYN ____________________________

HEART ____________________________

SKELETAL ____________________________

LUNGS ____________________________

NEUROLOGICAL ____________________________

SCREENING TESTS (DATES DONE AND RESULTS/DO AS NEEDED)

VISION ____________________________

TBC TEST ____________________________

HEARING ____________________________

SICKLE CELL ____________________________

SPEECH ____________________________

HGB ____________________________

DOST ____________________________

UA ____________________________

OTHER ____________________________

DIAGNOSIS ____________________________

RECOMMENDATIONS ____________________________

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? [ ] YES [ ] NO

DOES THIS CHILD HAVE ANY BEHAVIORAL OR HEALTH PROBLEMS WHICH WOULD PRECLUDE A FOSTER CHILD FROM BEING SAFELY PLACED IN THIS HOME? [ ] YES [ ] NO

Date ____________________________

Signature of Licensed Physician or Nurse approved to perform health assessments
CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Complete this section of the form for each child under age 16 residing in the foster home, excluding foster children.

Child's Name ____________________________ Date of Birth _______ Sex __________

Parent(s) Name(s) ____________________________________________________________

Address ___________________________________ Street __________________________
City __________________________ Zip Code __________________________

Please give dates for ALL immunization series completed by your child in the space below. Record MM/DD/YY. Update this for each time immunizations are given.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT, DT*, TD (*DT only if child is allergic to DTP)</td>
<td></td>
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<tr>
<td>POLIO</td>
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<tr>
<td>MMR</td>
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</tr>
<tr>
<td>RUBEOLA (MEASLES)</td>
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<tr>
<td>MUMPS</td>
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<td></td>
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</tr>
<tr>
<td>RUBELLA (GERMAN MEASLE)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>HHB (Hemophilus Infl. B) <strong>RECOMMENDED</strong></td>
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<td></td>
</tr>
<tr>
<td>HBV (Hepatitis B Vaccine) <strong>RECOMMENDED</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>VAR (Varicella-Chicken Pox) <strong>RECOMMENDED</strong></td>
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<td></td>
</tr>
</tbody>
</table>

This section is to be completed and signed by a nurse approved by DCF to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION)

ALLERGIES ____________________________
CURRENT MEDICATIONS ____________________________

NUTRITIONAL STATUS ____________________________

HEIGHT ____________________________
WEIGHT ____________________________

PHYSICAL EXAMINATION

HEAD ____________________________
EENT ____________________________
TEETH ____________________________
HEART ____________________________
LUNGS ____________________________

ABDOMEN ____________________________
GU ____________________________
GYN ____________________________
SKELETAL ____________________________
NEUROLOGICAL ____________________________

SCREENING TESTS (DATES DONE AND RESULTS/DO AS NEEDED)

VISION ____________________________
HEARING ____________________________
SPEECH ____________________________
DOST ____________________________

TBC TEST ____________________________
SICKLE CELL ____________________________
HGB ____________________________
UA ____________________________

OTHER ____________________________

DIAGNOSIS ____________________________

RECOMMENDATIONS ____________________________

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION? ☐ YES ☐ NO

DOES THIS CHILD HAVE ANY BEHAVIORAL OR HEALTH PROBLEMS WHICH WOULD PRECLUDE A FOSTER CHILD FROM BEING SAFELY PLACED IN THIS HOME? ☐ YES ☐ NO

Date ____________________________

Signature of Licensed Physician or Nurse approved to perform health assessments
Pet/Animal Approval Form (Page 1 of 2)

Name of Identified Foster Parent

Address  City  Zip  County

Please list below ALL indoor/outdoor pets at your residence.

<table>
<thead>
<tr>
<th>TYPE OF ANIMAL</th>
<th>BREED AND PET'S NAME</th>
<th>CURRENT VACCINATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ YES □ NO □ N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ YES □ NO □ N/A</td>
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<tr>
<td></td>
<td></td>
<td>□ YES □ NO □ N/A</td>
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<td></td>
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<td>□ YES □ NO □ N/A</td>
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<td>□ YES □ NO □ N/A</td>
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<td></td>
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<td>□ YES □ NO □ N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ YES □ NO □ N/A</td>
</tr>
</tbody>
</table>

Please attach a copy of current vaccinations for each pet listed above, or any applicable documentation indicating that your pet is exempt from vaccinations.

Check all statements that apply:

_____ I have attached current vaccinations for all pets/animals

_____ Based on my/our past experience with the pet(s)/animal(s) listed above, these pet(s)/animal(s) is/are friendly and non-aggressive, pose(s) no threat to the health, safety and well-being of child(ren) who may be living in my home, and have no history or past episodes of attacking or harming visitors or children.

Signature of Identified Foster Parent

Signature of Identified Foster Parent
TODAY'S DATE: ________________________________

LNAME1: ________________________________ FNAME1: ________________________________

LNAME2: ________________________________ FNAME2: ________________________________

DATE OF BIRTH1: _________________________ DATE OF BIRTH2: _________________________

SSN1: ________________________________ SSN2: ________________________________

RACE1: ___ African American ___ American Indian ___ Asian ___ Bi-Racial ___ Caucasian ___ Hispanic ___ Other

RACE2: ___ African American ___ American Indian ___ Asian ___ Bi-Racial ___ Caucasian ___ Hispanic ___ Other

ETHNICITY1: ___ Cuban ___ Central/ South American ___ Mexican ___ Puerto Rican ___ Other Spanish Origin ___ Other

ETHNICITY2: ___ Cuban ___ Central/ South American ___ Mexican ___ Puerto Rican ___ Other Spanish Origin ___ Other

LANGUAGE1: ___ English ___ Sign ___ Spanish ___ Croatian ___ Hmong ___ Laotian ___ Other

LANGUAGE2: ___ English ___ Sign ___ Spanish ___ Croatian ___ Hmong ___ Laotian ___ Other

LEVEL OF EDUCATION1: ___ Highschool ___ 2 yr. College ___ 4 yr. College ___ Masters ___ Doctorate ___ Other

LEVEL OF EDUCATION2: ___ Highschool ___ 2 yr. College ___ 4 yr. College ___ Masters ___ Doctorate ___ Other

INDUSTRY1: (circle one) Computer, Finance, Manufacturing, Tele-data communications

Advertising/Public Relations, Education, Healthcare, Media/Publishing, Transportation/Travel

Agriculture, Engineering, Homemaker, Government, Real-estate, Other

Banking, Factory, Hospitality, Human Services, Retail/Wholesale

INDUSTRY2: (circle one) Computer, Finance, Manufacturing, Tele-data communications

Advertising/Public Relations, Education, Healthcare, Media/Publishing, Transportation/Travel

Agriculture, Engineering, Homemaker, Government, Real-estate, Other

Banking, Factory, Hospitality, Human Services, Retail/Wholesale

KVC Recruitment/Licensing Database Form, revised 06/16/10
KVC RECRUITMENT/LICENSING DATA BASE FORM
RECRUITMENT - GENERAL (1 Page)

☐ New Entry    ☐ Update

DATE LOG COMPLETED: ___________________________________________

LNAME1: ___________________  FNAME1: ___________________  MI: ______

LNAME2: ___________________  FNAME2: ___________________  MI: ______

ADDRESS: ___________________________________________________

CITY: _______________________  COUNTY: _______________________

STATE: _______________________  ZIP: ___________________________

HOME PHONE: (___)____________  WORKPHONE1: (___)_____________

WORKPHONE2: (___)____________  OTHER PHONE: (___)____________

FAMILY’S EMAIL: ____________________________________________

KVC STAFF: _________________________________________________

KVC OFFICE: ___________________  KVC REGION: ___________________

INTERESTED IN (CHECK ALL THAT APPLY):

___ Satellite Foster Care  ___ Diversion/Transitional Foster Care  ___ Intensive Foster Care
___ Therapeutic Treatment Foster Care  ___ Police Protective Custody/Emergency (short-term)
___ NRKIN  ___ Relative Placement (Paid)  ___ Relative Placement (Unpaid)
___ Approved Home  ___ 16+years (Paid)  ___ Approved Home—16+years (Unpaid)  ___ Undecided
___ Adoption  ___ Foster To Adopt  ___ Specific Child  ___ Respite
___ Special Needs (MR/DD or Medically Fragile)

Total Bedrooms in Home__________ Number of Birth/Adopted Children Living in the Home__________

Number of Birth/Adopted Children Living in the Home over the Age of 16__________

Meet Income Guidelines? Y / N ______________

Convicted of a Prohibitive Offense? Y / N ______________

Do You Have a Pool or Pond without a Fence? Y / N ______________

Do You Have a Trampoline? Y / N ______________

Pets In The Home: ______ Dog  ______ Cat  ______ Other  ______ None
# KVC Behavioral HealthCare

## Foster Parent Mileage Report

**Provider Name:**

**Provider Address:**

**City:**

**State:**

**Zip:**

**Month:**

**Year:**

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**Mileage Grand Total and Reimbursement Amount**

\[ \text{Total Miles} \times \$0.34/\text{mi.} = \$ \]

I attest that the above information is accurate and represents mileage incurred in the performance of my Foster Parent responsibilities.

**Signature:**

**Date:**

---

Jshareacctg/FORMS/Blank RP Mileage Report

Revised 7/8/05
# FOSTER PARENT MILEAGE REPORT

**Provider Name:**

**Provider Address:**

**City:**

**State:**

**Zip:**

**Month:**

**Year:**

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Mileage Grand Total and Reimbursement Amount: \[ \text{Total Miles} \times 0.34/\text{mi.} = \] 

Please return this form by the 7th of each month to: Accounting Services, 21350 W. 153rd Street, Olathe, KS 66081

I attest that the above information is accurate and represents mileage incurred in the performance of my Foster Parent responsibilities.

**Signature:**

**Date:**

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Monthly Test - Tornado Drill

Monthly Test - Fire Drill

Smoke Detector Battery Test Completed on

Monthly Test - Smoke Detector

Fire Drill, Tornado Drill and Smoke Detector

Monthly Record

KVC Behavioral Healthcare, Inc.

KVC
KVC Foster Parent Mentoring Program

Congratulations on completing your MAPP training! You are one step closer to becoming a KVC foster parent. This is such an exciting process! As you take your first kiddos, you will soon experience a plethora of emotions, many positive and rewarding. However, it is also very normal to experience some anxiety and confusion as you start these new adventures! Your FSC will be here to support you during the licensing process and after you receive your license, but as an additional resource we have compiled a list of experienced foster families that have kindly offered to mentor new/newer foster families.

Feel free to read through this list and find a family or multiple foster families that you would like to connect with – and go ahead and contact them! It is not a requirement or expectation that you connect with other families but simply an extra resource as you begin this amazing journey!

Lenexa

Janet Oleson
8201 Caenen Lake Drive, Lenexa, KS 66215
913-888-8808
Preferred Contact Method: Phone calls, but she prefers to do most of the talking in person.
No email or texting.
Community Involvement: Lenexa United Methodist Church, swim team, and the local library. She also has a lot of experience with the 512 school district.
Special Skills: Janet has fostered for about 30 years and has a lot of experience with interracial placements and adoptions. She is a very calm person who has learned to take on problems slowly and not overreact.
-Jan has fostered a wide variety of foster children of various races, genders, ages, and behaviors. There is very little she has not encountered. Currently she has Caucasian brothers placed with her, aged 7 and 15 with significant learning deficits.
- Jan has adopted a total of 7 children out of foster care over the course of her life. Only one of these children still lives with her, the rest have grown up and some have had children of their own.

Merriam

Joe and Cindy Hansen
7120 Antioch Rd, Merriam, KS 66204
913-901-7010
Cindyhansen10@hotmail.com
Preferred Contact Method: Text, call or email
Community Involvement: Foster Parent Advisory Board; have participated in many
parent advisory board, and organizes a clothing closet for foster children.

**Special Skills:** A lot of experience with caring for medically fragile babies, experience with working with children with high behavioral and academic needs, works really well with biological families, has participated in many case plans and court hearings, and has a lot of experience with the foster care system.

-Fosters children 0-12 and typically take sibling sets. They also consider teens for respite and one night placements.

-Adopted a son over 10 years ago, that is now an adult and will be starting the adoption process again soon for one child.

-Willing to provide occasional respite and daycare for other foster homes. They have also been known to provide daycare for children while the family gets them enrolled in school.

-Kelly's church has expressed interest in providing meals to families when they take new placements. Please contact her when you take your first placement, so they can bring your family a meal; she can be contacted at church via phone: (913) 341-5820, ext. 113 or email: kellyp@heartlandchurch.org OR on her personal cell number above.

**Patrick and Barbie Shields**
16687 S. Lind Rd., Olathe, KS 66061
913-593-4636
Bartweety2@aol.com
Preferred Contact Method: Cell or email

**Community Involvement:** Life church, Spring Hill clothing closet, Southside mission, and bags for foster kids and donations for Christmas red bags through KVC.

-Barbie has a Criminal Justice degree and has worked with children who have high medical and/or behavioral needs. Barbie also has experience with sign language for infants and children with special needs.

-Fosters children 0-18 and enjoys working with children with special needs.


-Helps with respite, day care and one night placements, when available and has bed space.

**Overland Park**

**Titakorn ("Ghan") and Dava Bunyarattaphantu**
10220 Nieman Road
Overland Park, KS 66214
913-492-2572
davabsinging@gmail.com
Preferred contact method: Text, call or email

**Community Involvement:** Dava has been a preschool teacher of 2 & 3 year olds at Beautiful Savior Lutheran Preschool for 14 years, she teaches MAPP & Deciding Together classes at KVC, and is a very active volunteer in her sons’ school.

**Special Skills:** Dava and Ghan have a great deal of experience with children of all ages,
the Run, and other local activities in Overland Park.

**Special Skills:** Heather has been fostering for several years and has experience with the adoption process. She also has experience with the SSI process and working with mental health facilities, such as Johnson County Mental Health. She is a big advocate for children's educational needs and has partnered well with local schools. The focus of her home is helping kids understand how to be a part of a family.

- Heather primarily fosters girls with higher needs. She has had experience with children with physical aggression, verbal aggression, sexually acting out, and a variety of mental health needs.
- Heather has adopted one child. She adopted her daughter a year ago after a long adoption process.
- Heather is willing to take occasional respites, when she has the space and is off work.

**Peggy Zumbrunnen**
7243 Horton, OP, KS 66204
913-262-9620
peggyzurn@aol.com
Preferred Contact Method: email
Community Involvement: School activities
- Licensed to foster children aged 0-12
- She has adopted 2 children, one in 2006 and another in 2011.
- Available for occasional weekend respites

**Shawnee**

**Zach and Angie Cole**
11909 W 48th St, Shawnee
913-268-3751
zcoleminer@aol.com
Preferred Contact Method: Email or phone
Community Involvement: New City Church, 3&2 Baseball, Metro United Soccer, PTA groups, and Moms in Prayer.
Special Skills: Angie has a Social Work degree.
- Typically fosters infants, but have had all ages through early teen.
- The Cole's are in the process of adopting a child who has been with them for 2 years.
- Available for occasional weekend respites.

**Jamey and Carrie Collins**
23475 W 53rd Terrace
Shawnee, KS 66226
913-244-6647
Spring Hill

Duane and Debbie Degaravelles
209 E Nichols Street, Spring Hill, KS 66083
Duane Cell 209 345-0976
Debbie Cell 913 633-7398
ddegravel@gmail.com

Preferred Contact Method: Text, call or email

Community Involvement: Duane and Debbie were youth pastors in California for many years, then spent several years on the road as evangelist ministers in schools, churches and prisons. Duane was a founding member of the Overcomers Power Team and Power One Ministries and a National Platform Artist for Operation Starting Line which is a part of Chuck Colson's Prison Fellowship. Duane also served on the board as Vice President for Family Connections Adoption Agency in Modesto, California.

Special Skills: As Youth Pastors and Evangelists, their main focus was on youth and prison ministry. Debbie was the Founder of Funtastic Daycare in Modesto, California and for 14 years she worked closely with Modesto City Schools and their family childcare program for low-income families and at-risk youth. She had over 100 children go through her daycare and many of the families she is still in contact with also.
- Typically provide respite for other foster families and really enjoy having sibling sets.
- Also have experience with international adoptions.
QUESTIONS FOR RESOURCE PARENTS TO ASK PRIOR TO PLACEMENT OF A CHILD

Resource parents need to make an informed decision about their ability to meet the needs of any child placed with them. To help with this task the following is a list of questions to ask prior to accepting a placement. Please note that this is only a guide. KVC may not have all of this information. When a child is referred from another agency, KVC Admissions will only have the information supplied by the sponsoring agency.

1. Name, gender, age
   a. Does the child have any siblings placed in another home?
   b. Are there concerns with the child being around other children – older or younger?
   c. Has the child ever mistreated a pet?

2. Reason for placement & child’s permanency plan
   a. Is this an initial placement, disruption or police protective custody?
   b. Reintegration/adoption/independent living/guardianship)
   c. If case plan goal is Independent Living what are the specific goals for the youth, i.e. job, savings account, gathering household items, etc.?

3. Previous placements
   a. Reason for removal
   b. Ask to speak/phone to previous care provider
   c. Has the child made any allegations against previous foster parents/group home?

4. Reimbursement rate

5. Visitation
   a. Who does the child have visits with and how often? Is there a visitation schedule?
   b. Who is the child allowed to have contact with, i.e. siblings, grandparents, etc.?
   c. Who is the child NOT allowed to have contact with?
   d. Is there a risk of abduction?

6. Child’s medical history and current medical needs
   a. Medical diagnosis - When was the last KAN BE HEALTHY?
   b. Psychological diagnosis
   c. Current medication - Is the child bringing medication with them?
   d. Neurological diagnosis
   e. Dental

7. Siblings

8. Developmental level