KVC Behavioral HealthCare, Inc.
Child Placing Agency
7940 Marshall Drive
Lenexa, KS 66214
(913) 499-8100

RESOURCE 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 KDHE.

- ☐ 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.
- ☐ Family Financial Demographic
- ☐ 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). Completed only on Initial application.
- ☐ 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.
- ☐ Recruitment—Personal Information Data Base Form Send a completed copy with packet.
- ☐ 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.

CCL 401
Revised 9/09

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Child Care and Health Facilities
1000 SW Jackson*Suite 200
Topeka, Kansas 66612-1274
Phone (785) 296-1270 Fax (785) 296-7025
Website: www.kdheks.gov/kidsnet/

LICENSED/APPROVED FAMILY FOSTER HOME APPLICATION

Good beginnings last a lifetime. 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. INTENT OF THE APPLICANT/OPERATOR. COMPLETE ONE OF THE TWO BOXES BELOW (NEW OR RENEWAL).

NEW APPLICATION

_____ 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 who I/we wish to provide care.

I/we have or had a license, approval or certificate from the Kansas Department of Health and Environment

____ No	____ Yes	If yes, specify the following: 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 II. APPLICANT INFORMATION. COMPLETE ALL INFORMATION REQUESTED. PLEASE PRINT.

Applicant's Legal Name	Last	First	Middle	Work # ( ) Cell # ( )
Spouse/Co-Applicant Legal Name	Last	First	Middle	Work # ( ) Cell # ( )

Physical Address of Home (Street Address)		City	Zip Code + 4
County	Phone Number ( )	Email Address	
Mailing Address of the Home (if different than above)		City	Zip Code + 4

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.

HISTORY OF RESIDENCE (INITIAL APPLICANTS ONLY).

Have any household members, 18 years or older, resided outside the state of Kansas in the past 5 years?
_____ Yes (complete section below) _____ No (mark "N/A" in section below)

Report any residences outside the state of Kansas for the past 5 years, for household members 18 years or older. If additional space is needed, use the back of the form or attach to the application.

Name	Physical Street Address	City	State	Zip Code	County

The regulations require that a family foster home have stability in income or financial resource sufficient to meet the needs of the family without the support provided for individual children in foster care. One factor in determining that the family has such stability is to require information about employment history, including income, or other financial resource(s) and income at time of initial application. It is also necessary to document that the stability is maintained. **Employment history is required for all applications.**

Employment History (past five years for each applicant):

CURRENT JOB	Household Member #1	Household Member #2
Name		
Employer's Name		
Employer's Address		
Type of Business		
Job Title		
From/To (mm/yy)		
Current Annual Salary		
Supervisor's Name		
Supervisor's Phone		

PAST WORK HISTORY	Household Member #1	Household Member #2
Name		
Employer's Name		
Employer's Address		
Type of Business		
Job Title		
Last Salary		
From/To (mm/yy)		
Reason for Leaving		

Add additional sheets if necessary. If unemployed, retired, or disabled, specify income source(s) and amount(s).

_____ $_____

Applicant(s)/Licensee(s) is an employee or volunteer with a Child Placing Agency? _____ Yes _____ No

Applicant(s)/Licensee(s) is a relative or member of the governing body of the Sponsoring Child Placing Agency?

_____ Yes _____ No

If yes to either question above, indicate which Child Placing Agency? _____

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.**

Name	Street Address	City, State, Zip Code	Telephone Number

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 _____

TRAINING TITLE	TOPIC AREA	PRESENTER	DATE OF TRAINING	HOURS

APPLICANT NAME _____

TRAINING TITLE	TOPIC AREA	PRESENTER	DATE OF TRAINING	HOURS

SECTION VI. AGREEMENTS AND AUTHORIZED SIGNATURE(S), READ EACH STATEMENT AND SIGN THE APPLICATION WHEN COMPLETED.

I/We, the undersigned am [are the persons] named as the applicant or the authorized representative(s) of the owner listed in Section II.

I/We have read the laws and regulations governing the operation of this facility and it is the intention of this applicant to comply. I/We understand that I/we are responsible for meeting and maintaining compliance with all applicable child care licensing laws and regulations at all times.

I/We affirm that I/we have developed a written statement of philosophy, purpose, program orientation, and policy of operation including the sponsoring child placing agency's position on disciplinary methods to be used by staff. Corporal punishment is prohibited. The statement contains long and short term goals and is available to the designated representative of the Kansas Department of Health and Environment [KDHE], and to the public.

I/We understand that a new application may take up to 90 days for processing by KDHE once KDHE receives a complete application. I/We understand that I/we are not authorized to provide services related to family foster care prior to receiving a Temporary Permit or License from KDHE.

In accordance with Kansas Statutes Annotated 44-1009, I/we shall not refuse service to any person for reason of race, religion, color, sex, physical handicap, national origin or ancestry.

I/We attest, under penalty of perjury, that to the best of my/our knowledge, the information provided in this application is true and correct.

Applicant	Date (mm/dd/yyyy)

Co- Applicant	Date (mm/dd/yyyyy)

Reviewed and Approved by:

Sponsoring Child Placing Agency Licensing Worker	Date (mm/dd/yyyy)

Printed Name	Agency	Phone # ( )	Email Address

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 KDHE:

	Completed and signed application (CCL 401) (signed by the applicant(s) and sponsoring child placing agency licensing worker).
	KBI/SRS Background Check Request form (CCL 002) [You must keep a copy on file]
	Fingerprint-based Check of Criminal History/Out of State Child Abuse/Neglect Registry form (CCL 411) and fingerprint/registry results (if available at time of application)*
	Recommendation For Use by CPA & Intent to Place (CCL 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 (CCL 403) and the original Notice of Survey Finding form (CCL 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 KDHE. 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 KDHE upon completion.

RENEWAL APPLICATION

Submit only the following documents to KDHE:

	Completed and signed application (CCL 401) (signed by the licensee(s) and sponsoring child placing agency licensing worker).
	KBI/SRS Background Check Request form (CCL 002) [You must keep a copy on file]
	Continued Recommendation for Use by CPA (CCL 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 (CCL 403) and the original Notice of Survey Finding form (CCL 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 KDHE. 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 KDHE UNLESS REQUESTED.

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

CCL 002
Rev.9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Unit Phone: (785) 296-1270 Fax: (785) 296-0803
Foster Care Unit Phone: (785) 368-7015 Fax: (785) 296-7025
Website: www.kdhe.state.ks.us/kidsnet/

REQUEST FOR KBI/SRS CHILD ABUSE REGISTRY CHECK FOR CHILD CARE AND RESIDENTIAL CARE FACILITIES

Type of Facility: _____ Child Day Care Or School Age Programs _____ Child Care Resource & Referral Agency _____ 24 Hour Residential Care Including Family Foster Care _____ Child Placement Agency

Name of Facility exactly AS STATED ON THE LICENSE/CERTIFICATE	License/Certificate #	Date (MM/DD/YYYY)
Street Address of Facility	City	Zip Code + 4
First and Last Name of the Individual Completing This Form	Phone #	E-mail address

I. This request for background check is being completed to meet the requirements for (CHECK ONLY ONE):

_____ **Initial Application** _____ **Renewal** **The information provided on this form is to include:** yourself; all other persons 10 years of age and older living in the facility; all persons working and/or volunteering in the facility; all substitutes and other caregivers or helpers, including relief and support staff.

_____ **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).

All blank spaces 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, mark N/A. DO NOT include children or youth for whom you provide services. **COMPLETE BOTH SIDES OF THIS FORM.**

II. **Check Yes or No for each question below with regard to the persons listed on this form. If answering yes, complete the information in this section.**

Yes	No		Name of Person	Date	Court of Action and State and County
		Had a misdemeanor or felony conviction of a crime against persons, a sexual offense or crimes affecting family relationships and children?			
		Had a felony conviction under the uniform controlled substances act?			
		Been adjudicated (found or determined in a court of law to be be) a juvenile offender, delinquent, or miscreant?			
		Committed physical, mental or emotional abuse or neglect or sexual abuse as validated by SRS?			
		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?			
		Had parental rights terminated?			
		Signed a diversion agreement involving child abuse or a sexual offense?			
		Been found to be a disabled person in need of a guardian or conservator or both?			

Name of Facility exactly as stated on the license/certificate	License/Certificate #	Date Completed (MM/DD/YYYY)

K.A.R. 28-4-125(c) requires the facility to keep a copy of the completed form on file at the facility. Type or print plainly using black ink. Include **all** names each person used and/or uses.

(Names) Last	First	Middle	Maiden or Any Other Name Ever Used (Alias)	Social Security #	Date of Birth (MM/DD/YYYY)	Gender Male or Female	Race	Address - Street, City, Zip Code Home Phone #
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

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? _____

Family Financial Demographic

Please provide a copy of your most recent pay stubs

Applicant 1: _____ **Applicant 2:** _____

Monthly Net Income: (Include Wages, Social Security, Child Support, Alimony, Adoption Subsidy)

Amount:	Source:	Total Monthly Income:

Monthly Expenses:

For:	Amount:
Housing (rent or mortgage)	
Utilities (gas, electric, water, trash)	
Phone (include cell phones)	
Child Support Payments	
Automobile Loans	
Automobile Operating Expenses	
Food	
Medical	
Insurance	
Savings	
Clothing	
Credit Cards/Other Loans	
Investment/Retirement Savings	
Recreation and Entertainment	
Other (Explain)	
Other (Explain)	
Total Monthly Expenses:	

Total Amount in Savings:_____

Total Amount Accrued Investment/Retirement Income: _____

Additional Questions (if the answer is yes, please provide dates and circumstances):

Have you ever declared bankruptcy? □ No □ Yes : _____

_____

Have you ever had your wages garnished? □ No □ Yes: _____

_____

Have you ever been involved in a civil suit? □ No □ Yes: _____

_____

Have you ever received food stamps or cash assistance from the state? □ No □ Yes: _____

_____

Do you live in Section 8 or Income Based Housing? □ No □ Yes: _____

_____

We declare that to the best of our knowledge and belief, this statement is true, correct and complete.

_____ _____

Applicant 1 **Date**

_____ _____

Applicant 2 **Date**

KVC
BEHAVIORAL HEALTHCARE

Authorization Agreement for Direct Deposit

Please read this form carefully and write clearly.

If this is a new account, you must:

1. Already have the account set up at your bank
2. Find out if they accept direct deposits. Verify banks transit # and your account # (including dashes)
3. Notify the bank that you are going to set up direct deposit through accounting. Make sure that there isn't anything special you need to do as far as they are concerned.

Please check the action and fill out form below:

- □ Canceling account (complete item C below). Do not close an account unless you cancel it through accounting first.
- □ Direct Deposit already set up, changing $ amount only (complete C through E below).
- □ A new account (complete A through E below).
- □ A new account to replace a direct deposit already set up (complete A through E below).
  Which account are you replacing? _____

A. Bank Name: _____

B. Bank TBA #:

C. Bank Account #:

D. □ Checking □ Savings

E. □ Full Deposit

Please return to the Accounting Department with a voided check.

- I authorize Security Bank and the bank listed above to deposit my net pay or option thereof as indicated above into my account each payday.
- If funds to which I am not entitled are deposited to my account, I authorize Security Bank to direct the bank to return said funds.
- I understand that my deposit may not be credited to my account until 5:00 p.m. on the date indicated on the check voucher.

Applicant Signature: _____

Name (printed): _____ **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 adversonal, 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.

_____

Name Date

_____

Name Date

KVC Behavioral HealthCare
Child Placing Agency
7940 Marshall Drive
Overland Park, KS 66214
Phone: 913-499-8100

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).
  _____ 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.)

_____ **CHILD AND FAMILY:**

- I will respect the right of confidentially 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.**

_____ **ABUSE/NEGLECT:**

- I understand that any allegation of abuse or neglect may result in immediate removal of foster children from the home until the investigation is complete. Foster children may temporarily be placed in respite care until otherwise notified.
- I understand that by law, foster parents are mandated reporters and must call the Kansas Protection Report Center (1-800-922-5330) to report suspected child abuse or neglect for any child or youth, whether or not the child or youth is in care.

_____ **REIMBURSEMENT:**

- I agree to utilize foster care payments to meet the needs and expenses of the individual child. Expenses may include but are not limited to increase in utility bills due to placement, food, clothing, hygiene needs, school expenses, etc.
- I understand that if any child in my care is placed outside my home for respite, I will be paid for this period and will be responsible for payment to the respite provider at the rate reimbursed by KVC. There is no reimbursement for pre-placement visits.

_____ **EMERGENCIES:**

2. In case of emergencies, I agree to transport the child to the nearest hospital. I will take the CONSENT TO MEDICAL CARE form and the child's medical card and will refer questions concerning payment and billing to the child's social worker.
3. I agree to inform the KVC FSC or, if after hours, the CPA on call worker within 1 hour of any of the following critical incidents:

The death of a child or any resident of the family foster home	Use of illegal drugs
Attempted suicide	Placement disruption
Unanticipated psychiatric hospitalization	Emergency respite
Unanticipated medical hospitalization	Emergency change in placement
Emergency room visit	Police intervention and/or arrest
Communicable diseases and/or serious physical illness	Criminal assault of any kind
Serious accidental injury	Runaway from school, home or other
Health Department violations/confirmation	Sexual acting out between children/youth
Any action of a serious nature that poses physical or emotional danger to family members or staff	Negative press/media attention
Staff or foster family injuries as related to client action	Any other incident that is critical to the child(ren)'s care
Fire damage or damage to the home that affects the safety of the child in foster care	The physical restraint of a child in foster care
All complaint investigations by DCF	A vehicle accident involving any child in foster care
Alleged abuse or neglect	

- I agree to document critical incidents in writing and submit the documentation to my Family Service Coordinator within one business day.

_____ **DAY-TO-DAY DUTIES:**

1. I agree to comply with all KDH&E licensing standards and regulations.
2. I understand that KVC, DCF, or KDHE 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.
3. 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.
4. I will participate actively to facilitate the development and implementation of the child's Case Plan.
5. 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.
6. 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.
7. I will obtain DCF's permission, through KVC, prior to taking the child out of state or moving to another residence.

_____ **RESPITE:**

1. 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.
2. I agree to adhere to KDHE licensing laws and regulations when providing short-term respite care.
3. 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).
4. I understand that my Family Service coordinator must pre-approve any short-term respite care that I provide.
5. 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

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

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
Kansas
people matter

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.

NAME	RELATIONSHIP TO PLACEMENT
_____	_____
_____	_____

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 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

CCL 404
2002

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Bureau of Child Care Licensing and Regulation
1000 SW Jackson * Suite 200
Topeka, Kansas 66612-1274 * (785) 368-7015
Website: www.kdhe.state.us.ks/kidsnet/

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. (K.A.R. 28-4-314(c)(3) **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.**

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
AM Snack							
Lunch							
PM Snack							
Dinner							

Applicant/Licensee Signature Date

Applicant/Licensee Signature Date

CCL 005
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Unit: 785-296-1270 Fax 785-296-0803
Foster Care Unit: 785-368-7015 Fax 785-296-7025
Website: www.kdhe.state.ks.us/kidsnet/

YEARLY MECHANICAL SAFETY CHECK
FOR VEHICLES USED TO TRANSPORT CHILDREN IN A CHILD CARE FACILITY

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:

Band-aids (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

_____ _____
Facility Name Exactly as it Appears on the License or Certificate License or Certificate Number

_____
Street Address City County

I attest that this information is true and correct.

_____ _____
Signature for Facility Date (MM/DD/YYYY)

CCL 005
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Unit: 785-296-1270 Fax 785-296-0803
Foster Care Unit: 785-368-7015 Fax 785-296-7025
Website: www.kdhe.state.ks.us/kidsnet/

YEARLY MECHANICAL SAFETY CHECK FOR VEHICLES USED TO TRANSPORT CHILDREN IN A CHILD CARE FACILITY

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:

Band-aids (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

_____ _____
Facility Name Exactly as it Appears on the License or Certificate License or Certificate Number

_____
Street Address City County

I attest that this information is true and correct.

_____ _____
Signature for Facility Date (MM/DD/YYYY)

CCL 009
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Unit Phone: (785) 296-1270 Fax (785) 296-0803
Foster Care Unit Phone: (785) 368-7015 Fax 785-296-7025
Website: www.kdhe.state.ks.us/kidsnet/

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. Substitutes in a licensed day care home or licensed group day care home or registered family day care home are not required to obtain a health assessment. 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 KDHE form. Substitute forms are not accepted.

TO BE FILLED OUT BY CARE GIVER. (Please print)

Name of the facility exactly as stated on the license or certificate _____ License/Certificate # _____

Street Address _____ City _____ Zip Code _____ County _____

Check type of child care facility:

Reg. Family Day Care Home	Preschool	Attendant Care Facility	Maternity Center
Licensed Day Care Home	School Age Program	Detention Center	Residential Center
Group Day Care Home	Head Start Center	Family Foster Home	Secure Residential Treatment Facility
Child Care Center		Group Boarding Home	Secure Care Center

Name of Provider/Staff _____ Date of Birth _____
(First) (M) (Last) (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:		

	Yes	No		Yes	No		Yes	No
Headaches	___	___	Cancer	___	___	Alcoholism	___	___
Heart Disease	___	___	Diabetes	___	___	Arthritis	___	___
High Blood Pressure	___	___	Convulsions	___	___	Liver Disease	___	___
Lung Disease	___	___	Mental Illness	___	___	Other	___	___

If Yes, 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)**

CCL 009
Rev. 9/2003

Kansas Department of Health and Environment
Bureau of Child Care and Health Facilities
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Unit Phone: (785) 296-1270 Fax (785) 296-0803
Foster Care Unit Phone: (785) 368-7015 Fax 785-296-7025
Website: www.kdhe.state.ks.us/kidsnet/

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. Substitutes in a licensed day care home or licensed group day care home or registered family day care home are not required to obtain a health assessment. 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 KDHE form. Substitute forms are not accepted.

TO BE FILLED OUT BY CARE GIVER. (Please print)

_____ _____
Name of the facility exactly as stated on the license or certificate License/Certificate #

_____
Street Address City Zip Code County

Check type of child care facility:

Reg. Family Day Care Home	Preschool	Attendant Care Facility	Maternity Center
Licensed Day Care Home	School Age Program	Detention Center	Residential Center
Group Day Care Home	Head Start Center	Family Foster Home	Secure Residential Treatment Facility
Child Care Center		Group Boarding Home	Secure Care Center

Name of Provider/Staff _____ Date of Birth _____
(First) (M) (Last) (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:		

	Yes	No		Yes	No		Yes	No
Headaches	___	___	Cancer	___	___	Alcoholism	___	___
Heart Disease	___	___	Diabetes	___	___	Arthritis	___	___
High Blood Pressure	___	___	Convulsions	___	___	Liver Disease	___	___
Lung Disease	___	___	Mental Illness	___	___	Other	___	___

If Yes, 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)**

CCL 059
2002

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
BUREAU OF CHILD CARE LICENSING AND REGULATION
1000 SW JACKSON, SUITE 200, TOPEKA, KS 66612-1274
Phone (785) 368-7015 Fax (785) 296-7025
Website: www.kdhe.state.ks.us/kidsnet/

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.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /	/ /		
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /	/ /		
	MUMPS	/ /	/ /	/ /		
	RUBELLA (GERMAN MEASLE)	/ /	/ /	/ /		
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

The section is to be completed and signed by a nurse approved by KDHE 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 _____

DDST _____ 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

CCL 059
2002

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT
BUREAU OF CHILD CARE LICENSING AND REGULATION
1000 SW JACKSON, SUITE 200, TOPEKA, KS 66612-1274
Phone (785) 368-7015 Fax (785) 296-7025
Website: www.kdhe.state.ks.us/kidsnet/

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.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /	/ /		
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /	/ /		
	MUMPS	/ /	/ /	/ /		
	RUBELLA (GERMAN MEASLE)	/ /	/ /	/ /		
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

The section is to be completed and signed by a nurse approved by KDHE 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	_____
DDST	_____	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

KVC RECRUITMENT/LICENSING DATA BASE FORM
RECRUITMENT - PERSONAL INFORMATION (2 pages)

☐ Update

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)
Advertising/Public Relations, Agriculture, Banking, Computer, Education, Engineering, Factory, Finance, Healthcare, Homemaker, Hospitality, Insurance, Legal, Government, Human Services, Manufacturing, Media/Publishing, Real-estate, Retail/Wholesale, Tele-data communications, Transportation/Travel, Other

INDUSTRY2: (circle one)
Advertising/Public Relations, Agriculture, Banking, Computer, Education, Engineering, Factory, Finance, Healthcare, Homemaker, Hospitality, Insurance, Legal, Government, Human Services, Manufacturing, Media/Publishing, Real-estate, Retail/Wholesale, Tele-data communications, Transportation/Travel, Other

RECRUITMENT - PERSONAL INFORMATION (page 2 of 2)

OCCUPATION1: (circle one) Professional Administrative | Student Technical | Clerical Other | Military | Sales

OCCUPATION2: (circle one) Professional Administrative | Student Technical | Clerical Other | Military | Sales

MARITAL STATUS: _____ Married Couple _____ Unmarried Couple
_____ Single Female _____ Single Male

LIVING SITUATION: _____ Rent _____ Own Home

DOES FOSTER HOME/ RELATIVE SMOKE ____YES ____NO

UNIFIED SCHOOL DISTRICT #:_____

HIGH SCHOOL NAME:_____

MIDDLE SCHOOL NAME:_____

GRADE SCHOOL NAME:_____

KINDERGARTEN NAME:_____

OTHER:_____

RELIGION: _____ Catholic _____ Christian (i.e., Baptist, Protestant, Lutheran, etc.)
_____ Jewish _____ Moslem
_____Other

PLACE OF WORSHIP:_____

INCOME LEVEL: (circle one)

less than $15,000	$15,000-30,000	$30,001-45,000	$45,001-60,000
$60,001-75,000	$75,001-90,000	$90,001-105,000	$105,001-125,000
$125,001-150,000	$150,001-200,000	$200,001-250,000	$250,001-300,000
Over $300,000			

HOBBIES / SPECIAL INTERESTS:_____

_____

SUPPORT SYSTEMS:_____

_____

COMMUNITY INVOLVEMENT:_____

_____

UNIQUE STRENGTHS: _____

_____

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 Foster Parent Mentoring

Acknowledgment Form

Mentors-

1. Will contact family for introductions within one week of receiving mentee's contact information.

2. Mentor will be notified of first placement and call will be made within a week to set time for face-to-face visit within the first 30 days if possible.

3. Mentor will contact mentee at least monthly by phone, email, or face-to-face depending, on what works best for both parties.

4. Relationship between mentor and mentee will be allowed to develop as needed, and the FSC may be contacted with any questions or concerns.

Mentor/Mentee Expectations-

Mentors - 100% positive towards KVC, DFS, policies, court representatives, etc.

Plan an in-person visit within 30 days.

Make initial phone call.

Maintain confidentiality of all parties involved.

Contact mentee and follow-up with FSC in the event of difficulties.

Mentee - respond as able.

If mentee changes his/her mind about involvement in the program, FSC should be contacted.

If mentor isn't available, mentee may contact on-call/admissions for guidance.

By signing below, I acknowledge that I will do my best to facilitate a positive, friendly relationship as a mentor/mentee. I understand that the purpose of the mentoring program is to offer guidance to fellow foster homes, and I will treat my mentor/mentee with the highest level of respect. Out of respect for my counterpart, I will follow basic guidelines in communication so that this will be a positive experience for all parties. If this relationship doesn't work for any reason, I will discuss the situation with my FSC and determine if I might be a better fit with a different mentor/mentee.

Printed Name(s) _____

Signature _____ Date _____

Signature _____ Date _____

KVC Foster Parent Mentoring Information Sheet

Information will be shared exclusively with KVC and other foster parents, not families of foster children.

County FSC Name

Parent 1 (First & Last)

Parent 2 (First & Last)

Home Address Zip Code

Best Contact Number Additional Number

Email Address (1)

Email Address (2)

How long have you been a foster parent?

Do you have a current placement? If so, what age(s) & gender(s)?

What are some of your foster parenting special skills/experiences? CIRCLE ALL THAT APPLY

Special Needs	***Medically Fragile***	***Infants***	***Teenagers***
Independent Living	***Employed Foster Parents***	***Military***	***Medical Background***

Other

Share your experience! You CAN be a mentor in some areas, and a mentee in other areas!

Would you like to be a foster parent **MENTOR**?

The goal of a mentor is to give guidance to other foster families.

Would you like to be a foster parent **MENTEE**?

The mentee is someone seeking guidance and/or support on any fostering issues that arise.

What other information would you like to share about your family in order to assist with organizing mentors/mentees IF you are interested in participating in that arrangement?

What topics would you like to receive more information/training?

By signing, I give my consent to share the above information with other KVC foster parents for networking purposes.

Signature Date

Signature Date

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

9. **Is the child in therapy?**
   a. Where does the therapy take place?
   b. How often?
   c. What is the therapist's name and contact information?

10. **School last attended and current grade**
   a. Has the child been diagnosed with any learning disorders?
   b. Is the child attending special education?
   c. Doe the child have a current IEP?
   d. Does the child have an educational advocate?

11. **Known or suspected dangerous propensities/behaviors**
   a. Gang affiliations
   b. Fire setter
   c. History of lying or stealing
   d. Sexually acting out – Has the child been sexually abused? What is the gender of the abuser?
   e. Is there a risk of the child "running away"?
   f. Are there drug and/or alcohol concerns?
   g. Has the child been convicted of any crimes? If so, what, when and where?

12. **Legal status -** Have the child's parental rights been terminated?

13. **Anticipated length of placement**

14. **Is religion a concern?**

15. **Does child have any unusual habits? Likes? Dislikes?**

KVC- Behavioral HealthCare

FOSTER PARENT MILEAGE REPORT

Provider Name: ____________________

Provider Address: ____________________ **Month:** ____________

City: ____________ **State:** _____ **Zip:** ________ **Year:** ____________

Child's Name	Date	Destination	Odometer (Beginning)	Odometer (Ending)	Total Miles	Reason for Mileage		
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
						Family Visit ______ (Family Member)	Other ______	Court Hearing Case Plan
Mileage Grand Total and Reimbursement Amount						**x $.34/ mi. = $**		

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

Signature: ____________________ **Date:** ____________

J:/shareacctg/FORMS/Blank RP Mileage Report

Revised 7/8/05

KVC- Behavioral HealthCare

FOSTER PARENT MILEAGE REPORT

Provider Name: ______________________

Provider Address: ______________________ Month: ____________

City: ______________ State: _____ Zip: ________ Year: ____________

Child's Name	Date	Destination	Odometer (Beginning)	Odometer (Ending)	Total Miles	Reason for Mileage		
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
						☐ Family Visit ________ (Family Member)	☐ Other ________	☐ Court Hearing ☐ Case Plan
Mileage Grand Total and Reimbursement Amount						x $.34/ mi. = $		

Please return this form by the 7th of each month to: Accounting Services, 21350 W. 153rd Street Olathe, KS 66061

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

Signature: ______________________ Date: ______________

Our Home Address _____

Our Phone Number_____

Police 911

Fire Department 911

Ambulance 911

Poison Control 1-800-222-1222

Nearest Hospital _____

Primary Care Doctor

Name: _____
Address: _____
Phone Number: _____

KVC Afterhours Emergency Numbers

CPA 816-510-6664
Admissions..... 913-621-5753
Case Manager _____

Other Important Numbers:

_____
_____
_____
_____

KVC Behavioral HealthCare, Inc.

Monthly Record

Fire Drill, Tornado Drill and Smoke Detector

Monthly Test – Smoke Detector

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:

Smoke Detector Battery Test Completed on _____

Monthly Test – Fire Drill*

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:

Monthly Test – Tornado Drill*

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
NA	*NA*	*NA*	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	Date: Time:	*NA*	*NA*	*NA*

**All drill schedules need to be rotated with dates and times recorded.*

5/08