

Loftus-Vergari and Associates, Inc.

Foster Care and Adoption Program
65 North Washington Street
Wilkes-Barre, PA 18701

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APPLICATION TO OPERATE A FOSTER/ADOPTION CARE HOME

Please check the box in front of the program you are applying for:

- Regular Foster Care Respite Foster Care Adoption
 Foster/Adopt Therapeutic Foster Home Kinship

I hereby apply for contract and approval to operate a Foster Care / Adoption home.

Applicant's Signature

Date

Applicant's Signature

Date

In support of this request, I submit the following information:

Applicant's Name

(Last)

(First)

(Middle)

(Date of Birth)

Applicant's Address

(Street)

(City)

(County)

(State)

(Zip)

Applicant's Name (Significant Other)

(Last)

(First)

(Middle)

(Date of Birth)

Applicant's Address

(Street)

(City)

(County)

(State)

(Zip)

Phone:

(Home)

(Cell)

(Pager)

(Email)

OTHERS LIVING IN THE HOUSEHOLD

Full Name	Relationship	Date of Birth	SSN#	School attending and grade (if applicable)

1. Description of home where child will reside (check appropriate boxes)

Construction (Structure)

- Apartment
- Separate home
- Row house
- Duplex
- Other

Primary Materials

- Brick
- Stone
- Stucco
- Concrete block
- Wood frame

11. Do you have fire extinguishers in your home? Yes No

If yes, how many? _____

12. Number of phones: Land _____ Cell _____

13. List any family pets

14. Would your home be accessible to a person in a wheelchair? Yes No

15. Do any household members smoke? Yes No

16. Which applies to your home: I own it I rent it I am buying it

If renting, list the lease expiration date: _____

17. If you are buying your home, what bank or financial institution holds your mortgage?

Name Address

18. If renting, give name, address and phone number of landlord.

Name Address Phone

19. School District is located in: _____

20. Schools Foster Child will Attend:

21. Give the following information regarding each household member's physician(s).

Physician's Name	Address	Phone	Family Members seen by the Doctor

22. How did you first learn about our program?

23. Briefly state the main reason(s) for your interest in becoming a foster parent.

COMMENTS

- 36. Have either of you had previous contact with any public child welfare or juvenile justice system for any reason?
 Yes No

- 37. Is any member of your household currently an inmate of a penal or correctional institution or on parole or probation?
 Yes No

- 38. Has any member of your household ever been convicted of a crime other than a minor traffic violation?
 Yes No

- 39. Have either of you had any involvement with family court for any reason (P.F.A., Custody)?
 Yes No

- 40. Have either of you had any arrests related to drugs or alcohol?
 Yes No

- 41. Have either of you had any hospitalizations related to drugs or alcohol?
 Yes No

- 42. Have either of you filed for bankruptcy within the last 10 years?
 Yes No

*** APPLICANT NOTE:**

Failure to disclose information may result in the denial of your application, your dismissal from the program, or removal of children from your home.

APPLICANT 1

Full Name: _____
Last First Middle

Date of Birth: _____
Month Day Year

Social Security #: _____ Drivers License #: _____

Race: _____

Primary Language Spoken: _____ Other Language Spoken: _____

U.S. Citizen: Yes No If no, (what is your status) _____

Education (schools attended)

Elementary _____

High School _____ Year of Graduation _____

College _____ Type of Degree _____

Religion:

Denomination _____

Place of Worship _____

Spiritual Leader _____

Address _____

Employment: (History for the last 10 years)

Current Place of Employment: _____

Address: _____

Name of Supervisor: _____

Length of Employment: _____ Salary: _____

Previous Employers: (Within the last 10 years)

Name of Employer				
Location (City)				
Length of Employment	From:		To:	
Job Title				
Full or Part-time				
Job Description (your duties)				
Reason for Leaving				
Name of Employer				
Location (City)				
Length of Employment	From:		To:	
Job Title				
Full or Part-time				
Job Description (your duties)				
Reason for Leaving				
Name of Employer				
Location (City)				
Length of Employment	From:		To:	
Job Title				
Full or Part-time				
Job Description (your duties)				
Reason for Leaving				
Name of Employer				
Location (City)				
Length of Employment	From:		To:	
Job Title				
Full or Part-time				
Job Description (your duties)				
Reason for Leaving				

Military:

Dates Enlisted: _____

Branch: _____

Type of Discharge: _____

Family of Origin:

Name of Father: _____

Address: _____

Maiden Name of Mother: _____

Address: _____

Name and Address of Siblings:

Marriage:

Former Marriages:

Name of Former Spouse: _____

Date of Former Marriage: _____

Date and Reason for Dissolution of Marriage:

Children of Former Marriages/Relationships

Name	DOB	Present Location

LIST ANY MAJOR ILLNESS OR SURGERY WHICH YOU HAVE HAD.

Type of Illness or Surgery	Type:	
	When:	
Type of Illness or Surgery	Type:	
	When:	
Type of Illness or Surgery	Type:	
	When:	
Are you currently taking any prescription medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details.		
Names of Medications:		

Please list any hobbies, pastimes, recreational activities, civic involvement, religious activities, sports, coaching involvement, scouting history, etc.

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APPLICANT 2

Full Name: _____

Last

First

Middle

Date of Birth: _____

Month

Day

Year

Social Security #: _____ Drivers License #: _____

Race: _____

Primary Language Spoken: _____ Other Language Spoken: _____

U.S. Citizen: Yes No If no, (what is your status) _____

Education (schools attended)

Elementary _____

High School _____ Year of Graduation _____

College _____ Type of Degree _____

Religion:

Denomination _____

Place of Worship _____

Spiritual Leader _____

Address _____

Employment: (History for the last 10 years)

Current Place of Employment: _____

Address: _____

Name of Supervisor: _____

Length of Employment: _____ Salary: _____

Previous Employers: (Within the last 10 years)

Name of Employer				
	Location (City)			
	Length of Employment	From:	To:	
	Job Title			
	Full or Part-time			
	Job Description (your duties)			
	Reason for Leaving			
Name of Employer				
	Location (City)			
	Length of Employment	From:	To:	
	Job Title			
	Full or Part-time			
	Job Description (your duties)			
	Reason for Leaving			
Name of Employer				
	Location (City)			
	Length of Employment	From:	To:	
	Job Title			
	Full or Part-time			
	Job Description (your duties)			
	Reason for Leaving			
Name of Employer				
	Location (City)			
	Length of Employment	From:	To:	
	Job Title			
	Full or Part-time			
	Job Description (your duties)			
	Reason for Leaving			

Military:

Dates Enlisted: _____

Branch: _____

Type of Discharge: _____

Family of Origin:

Name of Father: _____

Address: _____

Maiden Name of Mother: _____

Address: _____

Name and Address of Siblings:

Marriage:

Former Marriages:

Name of Former Spouse: _____

Date of Former Marriage: _____

Date and Reason for Dissolution of Marriage: _____

Children of Former Marriages/Relationships

Name	DOB	Present Location

LIST ANY MAJOR ILLNESS OR SURGERY WHICH YOU HAVE HAD.

Type of Illness or Surgery	Type:	
	When:	
Type of Illness or Surgery	Type:	
	When:	
Type of Illness or Surgery	Type:	
	When:	
Are you currently taking any prescription medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details.		
Names of Medications:		

Please list any hobbies, pastimes, recreational activities, civic involvement, religious activities, sports, coaching involvement, scouting history, etc.

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The following information will assist us in evaluating your application to operate a Specialized Foster Care Home.

If a particular question does not apply to you, please write "none" or "N/A" (not applicable) in the space provided.

Please give the following information for five non-related personal references. A letter will be sent asking them to respond to a few questions. Their responses will be needed before approval can be made.

1. (Friend or Neighbor)
Name _____
Address _____
Telephone Number _____

2. (Friend or Neighbor)
Name _____
Address _____
Telephone Number _____

3. (Friend or Neighbor)
Name _____
Address _____
Telephone Number _____

4. (Friend or Neighbor)
Name _____
Address _____
Telephone Number _____

5. (Friend or Neighbor)
Name _____
Address _____
Telephone Number _____

(Spiritual Leader)
Name: _____
Place of Worship _____
Address _____
Telephone Number _____

HOUSEHOLD INFORMATION

The financial status of our foster homes must be secure. There must be some definite income, which is adequate to care for the family needs. Please furnish the following information using monthly figures.

Monthly Household Income

Employment:

(Monthly take-home)

Applicant

Alternate

Other Income (specify source, such as Soc. Sec., Retirement, Etc.)

Source	Amount
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

TOTAL INCOME/yr

Monthly Household Expenses

Housing:

Rent/Mortgage:

Utilities:

Insurance: (year)

Monthly Installment Payments

Auto:

Loan:

Charge Accts:

Other:

Insurance:

Health:

Life:

Auto:

Other:

Groceries (estimate)

Per Month

Other (estimate)

i.e., clothing,
medical, drugs,
recreation

Per Month

TOTAL EXPENSES/yr

We are aware that the following questions are somewhat delicate, however, we must ask them in order to properly evaluate your home. Answering yes to any of the questions does not necessarily disqualify you from consideration for becoming a foster parent.

The following information is required by the Pennsylvania Department of Public Welfare.

Proof of Insurance:

Vehicle Insurance: _____

Insurance Company: _____

Policy Number: _____

Expiration Date: _____

Homeowner's Insurance:

Insurance Company: _____

Policy Number: _____

Expiration Date: _____

Please name an individual other than yourself (selves) who would most likely be available to provide care for the child/youth in your absence, i.e., short term babysitting services.

Name: _____

Address: _____

Telephone: _____

Home

Cell

Pager

Relationship to you: _____

The information on this application is true to the best of my knowledge.

I/We understand that this study and inspection of my/our home might include, but not be limited to a written contract between the Specialized Foster Care administration and my/ourselves.

Signature

Signature

Date

Date

Thank you for considering becoming a foster parent with Loftus-Vergari and Associates. I appreciate all the time and effort you have put into this application and I will be in contact with you as soon as possible. If you have any questions please feel free to contact me.