



St. Aemilian-Lakeside Treatment Foster Care Program

8901 W. Capitol Dr., Milwaukee, WI 53222,

I am interested in providing:

- Treatment Foster Care
- Respite Care
- Independent Living
- All of the Above

DATA SHEET FOR RESPITE OR TREATMENT FOSTER CARE APPLICANTS

The information requested on this form is necessary for the foster home licensing process. Please answer each question completely. If additional space is required, use another sheet of paper. Applications not complete will be sent back to you.

APPLICANT: Where did you hear about our program?

Name: _____
Last
First
Middle
Maiden

Date of Birth: ____/____/____ Birthplace: _____ Sex: Male Female
City/State

Years of Education: _____ Race: _____ U.S. Citizen? YES NO

Social Security No: _____-____-____ Driver's License No: _____

Home Phone No: _____-____-____ Work Phone No: _____-____-____

Best time to call at home? _____ Can we call you at work? _____
 Married Single Widowed Divorced Separated Legally Separated

CO-APPLICANT:

Name: _____
Last
First
Middle
Maiden

Date of Birth: ____/____/____ Birthplace: _____ Sex: Male Female
City/State

Years of Education: _____ Race: _____ U.S. Citizen? YES NO

Social Security No: _____-____-____ Driver's License No: _____

Home Phone No: _____-____-____ Work Phone No: _____-____-____

Best time to call at home? _____ Can we call you at work? _____
 Married Single Widowed Divorced Separated Legally Separated

RESIDENCE:

Address: _____
Street

City
State
Zip code

Email Address: _____ Length of time at residence: _____

Directions to home: _____

Total Number of bedrooms in your home: _____ Sleeping arrangements for foster children: _____

LIVING IN THE HOME: List everyone, other than applicant/co-applicant, who is living in the home.

Name	Sex	Birthdate	School and Grade or Occupation	Relationship

APPLICANT’S EMPLOYMENT/FINANCIAL INFORMATION:

Are you currently employed: Yes No If “yes,” please complete the following:

Current Employer: _____ Occupation/Position: _____

Work Hours: Days: _____ Times: _____

If “no,” please complete the following: What is your source of income? _____

Government assistance (AFDC, Social Security, Food Stamps)

Other (Specify Sources): _____

CO-APPLICANT’S EMPLOYMENT/FINANCIAL INFORMATION:

Are you currently employed: Yes No If “yes,” please complete the following:

Current Employer: _____ Occupation/Position: _____

Work Hours: Days: _____ Times: _____

If “no,” please complete the following: What is your source of income? _____

Government assistance (AFDC, Social Security, Food Stamps)

Other (Specify Sources): _____

PREVIOUS FOSTER CARE EXPERIENCE:

Have you ever applied for a foster home license?: Yes No If yes, was the license ever issued?: Yes No

If “yes,” Dates you were licensed: From: _____ To: _____

Name of Foster Care Agency(s): _____ Licensing Worker: _____

Applicant Signature

Date Completed

Co-Applicant Signature

Date Completed

***Please complete the attached DCF 38.05 Licensee Qualifications form attached.

***Please complete the attached Authorization for Release of Information and Records form attached.

(Applicant and Co-applicants must sign separate Release of Information forms – thank you.)

St. Aemilian-Lakeside

Foster Care Services

DCF 38.05 LICENSEE QUALIFICATIONS SIGNATURE SHEET

The requirements of this section shall be met in addition to the requirements of s. DCF 56.04

DCF 38.05 Licensee Qualifications:

- **Each applicant must be at least 21 years old.
- **Applicants who have a home based daycare or a job that requires second shift work hours may not qualify for the Treatment Foster Care program.
- **Proof of legal US residency is required (a copy of: a birth certificate or a copy of a social security card and driver’s license or a copy of a visa)

(1) A person or persons licensed to operate a treatment foster home shall possess at least 2 of the following: (**Please note, each applicant must meet these requirements)

Please check the box if you meet the listed requirement (if there is an applicant and co-applicant please put initials in box for each requirement you each possess):

	1. A minimum of one year of experience as a licensed foster parent, understood as having been a licensed foster parent who had a child placed in his/her home for at least a year.
	2. A minimum of 5 years of experience working with or parenting children.
	3. A minimum of 500 hours of experience as a respite care provider for children under the supervision of a human services agency.
	4. A high school diploma or the equivalent.
	5. A substantial relationship with the child to be placed through previous experience as a staff person or volunteer involved in the child’s case or as a family member or friend of the family of the treatment foster child.

_____ _____ _____ _____
 Applicant Date Co-Applicant Date

St. Aemilian Lakeside Foster Care Services

8901 W Capital Dr, Milwaukee, WI 53222
Fax: 414-465-5790

Purpose: Authorization for Release of Information and Records as part of the application/ re-licensing process for becoming a caregiver in Foster Care Services

To the Applicant, Licensee, or other adult in the home:

Be sure all lines are filled in before you sign this form.

Be sure the release is in your best interest.

By signing this form, agencies/individuals listed below will be authorized to release any and all information regarding any referrals or contacts regarding the following: criminal history, child abuse and neglect, elderly abuse and neglect, welfare abuse, adoption and foster care studies, or any other pertinent information.

List all addresses resided at within the past **five years** (including current address) for Police Department background checks:

_____	_____	_____
Street Address	Street Address	Street Address
_____	_____	_____
City	City	City

List all Counties and States resided within the past **five years** for Department of Health and Human Service (DHS) background checks:

_____	_____	_____
County, State	County, State	County, State

The Department of Justice Crime Information Bureau (CIB)

Information from Therapist/Counselor: _____ (if applicable)
Therapist/ Counselor name and agency

Day care licensing agency applied with: _____ (if applicable)
Day care licensing agency

Other Foster Care agency applied with: _____ (if applicable)
Foster care agency

Please list your current legal name and any other names you have been known by including maiden names:

_____	_____
Last, First, Middle	Last, First, Middle
_____	_____
Last, First, Middle	Last, First, Middle

Date of Birth: _____ Social Security Number: _____ Driver's License Number: _____

This authorization expires (90 days for written information; 1 year for on-going communication) after this date: _____
Today's date

The information released to the agency specified above cannot be passed to any other agency/individual without your authorization. I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initiated above. This authorization form is intended to be in conformance with s. 48.685, Stats., Ch. DHS 12, S. DCF 56.05 or any other part of this chapter (DCF 56) for the applicant/licensee to not be granted a license or make the applicant/licensee an ineligible candidate for foster parent status.

I authorize copies of this release form to be sent via fax/mail to the agencies specified above through the expiration date.

Signature: _____ Date: _____

-----**For Open Records Usage Only**-----

Name of Agency: _____

- If above named individual has no record, please check here, sign and date: _____
- If above named individual has a record, please check here, sign, date and attach record: _____

St. Aemilian Lakeside Foster Care Services

8901 W Capital Dr, Milwaukee, WI 53222
Fax: 414-465-5790

Purpose: Authorization for Release of Information and Records as part of the application/ re-licensing process for becoming a caregiver in Foster Care Services

To the Applicant, Licensee, or other adult in the home:

Be sure all lines are filled in before you sign this form.

Be sure the release is in your best interest.

By signing this form, agencies/individuals listed below will be authorized to release any and all information regarding any referrals or contacts regarding the following: criminal history, child abuse and neglect, elderly abuse and neglect, welfare abuse, adoption and foster care studies, or any other pertinent information.

List all addresses resided at within the past **five years** (including current address) for Police Department background checks:

_____	_____	_____
Street Address	Street Address	Street Address
_____	_____	_____
City	City	City

List all Counties and States resided within the past **five years** for Department of Health and Human Service (DHS) background checks:

_____	_____	_____
County, State	County, State	County, State

The Department of Justice Crime Information Bureau (CIB)

Information from Therapist/Counselor: _____ (if applicable)
Therapist/ Counselor name and agency

Day care licensing agency applied with: _____ (if applicable)
Day care licensing agency

Other Foster Care agency applied with: _____ (if applicable)
Foster care agency

Please list your current legal name and any other names you have been known by including maiden names:

_____	_____
Last, First, Middle	Last, First, Middle
_____	_____
Last, First, Middle	Last, First, Middle

Date of Birth: _____ Social Security Number: _____ Driver's License Number: _____

This authorization expires (90 days for written information; 1 year for on-going communication) after this date: _____
Today's date

The information released to the agency specified above cannot be passed to any other agency/individual without your authorization. I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initiated above. This authorization form is intended to be in conformance with s. 48.685, Stats., Ch. DHS 12, S. DCF 56.05 or any other part of this chapter (DCF 56) for the applicant/licensee to not be granted a license or make the applicant/licensee an ineligible candidate for foster parent status.

I authorize copies of this release form to be sent via fax/mail to the agencies specified above through the expiration date.

Signature: _____ Date: _____

-----**For Open Records Usage Only**-----

Name of Agency: _____

- If above named individual has no record, please check here, sign and date: _____
- If above named individual has a record, please check here, sign, date and attach record: _____