



# Lutheran Children and Family Service

*Connecting People – Creating Change*

File #: \_\_\_\_\_  
(For office use only)

## Lutheran Children and Family Service Resource Parent Application

Date \_\_\_\_\_

### **Applicant #1**

Name \_\_\_\_\_  
First Middle Last Maiden/Alias

Address \_\_\_\_\_  
Street #/Name, Apt#, and/or PO Box

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_ Best time to call \_\_\_\_\_

### **Applicant #2**

Name \_\_\_\_\_  
First Middle Last Maiden/Alias

Address \_\_\_\_\_  
Street #/Name, Apt#, and/or PO Box

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_ Best time to call \_\_\_\_\_

### **Directions to your home or nearest major Intersection.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Personal Information

### Applicant #1

Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_ Are you a USA citizen?  Yes  No

Have you lived in Pennsylvania the past 5 years?  Yes  No *If not, please attach your previous addresses.*

Ethnicity \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Please attach a copy of your card*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Applicant #2

Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_ Are you a USA citizen?  Yes  No

Have you lived in Pennsylvania the past 5 years?  Yes  No *If not, please attach your previous addresses.*

Ethnicity \_\_\_\_\_ Social Security Number \_\_\_\_\_  
*Please attach a copy of your card*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Family History (parent's and siblings):

### Applicant #1

Father's Name \_\_\_\_\_ Deceased  Yes  No

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Deceased  Yes  No

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Step-Parent's Name \_\_\_\_\_

Siblings	State of Residence

### Applicant #2

Father's Name \_\_\_\_\_ Deceased  Yes  No

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Deceased  Yes  No

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Step-Parent's Name \_\_\_\_\_

Siblings	State of Residence

## Personal History

### Applicant #1

Were you raised in a single parent home or a two parent home? \_\_\_\_\_

Were you or any of your siblings a victim of emotional, sexual or physical abuse? \_\_\_\_\_

Did either of your caregivers use drugs or alcohol?  Yes  No

Was either of your parents a victim of domestic violence?  Yes  No

Who was the disciplinarian? \_\_\_\_\_

What style of discipline did your mother and father use? \_\_\_\_\_

Did you undergo any traumatic events as a child?  Yes  No

Were you ever hospitalized as a child?  Yes  No

If yes, was it a negative or positive experience? \_\_\_\_\_

If it was a negative experience, has it affected your willingness to seek medical treatment?  Yes  No

Did either of your parents have previous marriages?  Yes  No

If yes, please tell us about them and explain why and how the marriages ended. \_\_\_\_\_

Have your parents ever had a marital separation?  Yes  No

How were you disciplined as a child? \_\_\_\_\_

Were your parent's fair when disciplining you?  Yes  No

Was there any difference between the way you were disciplined and the way your siblings were disciplined?  Yes  No

If yes, please explain how it was different. \_\_\_\_\_

Describe your relationship with your siblings. \_\_\_\_\_

### Applicant #2

Were you raised in a single parent home or a two parent home? \_\_\_\_\_

Were you or any of your siblings a victim of emotional, sexual or physical abuse? \_\_\_\_\_

Did either of your caregivers use drugs or alcohol?  Yes  No

Was either of your parents a victim of domestic violence?  Yes  No

Who was the disciplinarian? \_\_\_\_\_

What style of discipline did your mother and father use? \_\_\_\_\_

Did you undergo any traumatic events as a child?  Yes  No

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If yes, please explain how it was different. \_\_\_\_\_

Describe your relationship with your siblings. \_\_\_\_\_

## Health History

### Applicant #1

Have you ever been hospitalized or treated through mental health out-patient services?  Yes  No  
If yes, explain when, for how long, and therapist information. \_\_\_\_\_

Have you ever been prescribed medication to treat anxiety or depression or another mental health issue?  Yes  No  
If yes, describe medication and how long individual was or is receiving the medications and who oversees the regiment or dose. \_\_\_\_\_

Have you ever been treated for an addiction?  Yes  No  
If yes, please explain. \_\_\_\_\_

Have you ever had a driver's license ever been suspended for DUI?  Yes  No  
Have you ever been arrested for alcohol or drug-related offenses?  Yes  No  
If yes, please explain. \_\_\_\_\_

Do you have health insurance?  Yes  No  
Please provide Primary Physician Information and Insurance Carrier. \_\_\_\_\_

Is everyone in the family covered by health insurance?  Yes  No  
How often does each household member see a physician? \_\_\_\_\_

If you do not have health insurance do you plan on obtaining health insurance prior to certification?  
 Yes  No

Do you have a family history of heart problems?  Yes  No

Do you have a family history of cancer?  Yes  No

Do you have a family history of diabetes?  Yes  No

### Applicant #2

Have you ever been hospitalized or treated through mental health out-patient services?  Yes  No  
If yes, explain when, for how long, and therapist information. \_\_\_\_\_

Have you ever been prescribed medication to treat anxiety or depression or another mental health issue?  Yes  No  
If yes, describe medication and how long individual was or is receiving the medications and who oversees the regiment or dose. \_\_\_\_\_

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If you do not have health insurance do you plan on obtaining health insurance prior to certification?  
 Yes  No

Do you have a family history of heart problems?  Yes  No

Do you have a family history of cancer?  Yes  No

Do you have a family history of diabetes?  Yes  No

## Educational History

### **Applicant #1**

Highest Educational Level Achieved \_\_\_\_\_ HS Diploma/GED \_\_\_\_\_ College \_\_\_\_\_

Name of School \_\_\_\_\_

Additional Training or Degree \_\_\_\_\_

Do you speak or write any languages other than English? \_\_\_\_\_

Describe your proficiency level? \_\_\_\_\_ Do you know Sign Language?  Yes  No

How important is education to you? \_\_\_\_\_

If you had to travel to keep a child enrolled in their neighborhood school would you?  Yes  No

What are the educational expectations for a child in your home? \_\_\_\_\_

What are your feelings about public verses private schools? \_\_\_\_\_

Do you worry that teachers will have a negative influence on a child or youth?  Yes  No

Describe your local elementary, middle and high school. \_\_\_\_\_

What advantages would a child have if they attended any of those schools? \_\_\_\_\_

Do you have any concerns about the school where a child would be enrolled?  Yes  No

If you currently have children in your home, what are their current strengths in school and what areas do they struggle in? \_\_\_\_\_

How have you addressed the areas of concern? \_\_\_\_\_

How have you promoted the areas of strength? \_\_\_\_\_

### **Applicant #2**

Highest Educational Level Achieved \_\_\_\_\_ HS Diploma/GED \_\_\_\_\_ College \_\_\_\_\_

Name of School \_\_\_\_\_

Additional Training or Degree \_\_\_\_\_

Do you speak or write any languages other than English? \_\_\_\_\_

Describe your proficiency level? \_\_\_\_\_ Do you know Sign Language?  Yes  No

How important is education to you? \_\_\_\_\_

If you had to travel to keep a child enrolled in their neighborhood school would you?  Yes  No

What are the educational expectations for a child in your home? \_\_\_\_\_

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How have you addressed the areas of concern? \_\_\_\_\_

How have you promoted the areas of strength? \_\_\_\_\_

## Employment and Financial Data

### Applicant #1

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Working Hours \_\_\_\_\_ Length of Employment \_\_\_\_\_

Monthly Income \_\_\_\_\_ Other Income \_\_\_\_\_

Previous Employer(s) (If less than 5 years at current position) \_\_\_\_\_

Are you happy with your current job or position?  Yes  No

Do you see yourself there until retirement?  Yes  No

How would you describe your relationship with your supervisor? \_\_\_\_\_

How often do you go to work early? How often do you work late? \_\_\_\_\_

If you could make one change at your place of employment, what would it be? \_\_\_\_\_

Have you ever left a job without having a replacement job?  Yes  No

If yes, please explain. \_\_\_\_\_

Have you ever been fired?  Yes  No If yes, please explain. \_\_\_\_\_

Have you ever been reprimanded at work for losing your temper with customers or coworkers?

Yes  No If yes, please explain. \_\_\_\_\_

Do you ever socialize with your coworkers?  Yes  No

Do you have Life Insurance coverage?  Yes  No

Name of Insurance Coverage \_\_\_\_\_

What is your means of transportation? \_\_\_\_\_

Driver's license number \_\_\_\_\_ Expiration Date \_\_\_\_\_

### Applicant #2

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Name of Supervisor \_\_\_\_\_

Working Hours \_\_\_\_\_ Length of Employment \_\_\_\_\_

Monthly Income \_\_\_\_\_ Other Income \_\_\_\_\_

Previous Employer(s) (If less than 5 years at current position) \_\_\_\_\_

Are you happy with your current job or position?  Yes  No

Do you see yourself there until retirement?  Yes  No

How would you describe your relationship with your supervisor? \_\_\_\_\_

How often do you go to work early? How often do you work late? \_\_\_\_\_

If you could make one change at your place of employment, what would it be? \_\_\_\_\_

Have you ever left a job without having a replacement job?  Yes  No

If yes, please explain. \_\_\_\_\_

Have you ever been fired?  Yes  No If yes, please explain. \_\_\_\_\_

Have you ever been reprimanded at work for losing your temper with customers or coworkers?

Yes  No If yes, please explain. \_\_\_\_\_

Do you ever socialize with your coworkers?  Yes  No

Do you have Life Insurance coverage?  Yes  No

Name of Insurance Coverage \_\_\_\_\_

What is your means of transportation? \_\_\_\_\_

Driver's license number \_\_\_\_\_ Expiration Date \_\_\_\_\_

### Military Service

#### Applicant #1

Branch \_\_\_\_\_ Dates \_\_\_\_\_

Locations \_\_\_\_\_

Present Status (Reserves/Retired) \_\_\_\_\_

#### Applicant #2

Branch \_\_\_\_\_ Dates \_\_\_\_\_

Locations \_\_\_\_\_

Present Status (Reserves/Retired) \_\_\_\_\_

### Marriage/Partnership Information

#### Applicant #1

Do you have previous marriages?  Yes  No

What are the dates of the previous marriages, what was the dates when the marriages ended?

What was the reason the marriages or partnerships ended? \_\_\_\_\_

Has a Protection from Abuse order ever been filed against you?  Yes  No

Have you ever filed a protection from abuse order against someone?  Yes  No

Have you ever filed a restraining order against someone?  Yes  No

If you answered yes to any or all of these questions, please explain and include legal name at the time of filing and the location where petition was filed. Also include if it is still valid or has it been lifted.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Children of your own, living away from home.

Name	DOB	Address

**Applicant #2**

Do you have previous marriages?  Yes  No

What are the dates of the previous marriages, what was the dates when the marriages ended?

What was the reason the marriages or partnerships ended? \_\_\_\_\_

Has a Protection from Abuse order ever been filed against you?  Yes  No

Have you ever filed a protection from abuse order against someone?  Yes  No

Have you ever filed a restraining order against someone?  Yes  No

If you answered yes to any or all of these questions, please explain and include legal name at the time of filing and the location where petition was filed. Also include if it is still valid or has it been lifted.

**Children of your own, living away from home.**

Name	DOB	Address

**Child Care/Foster Care/Adoption Experience**

**Applicant #1**

Have you ever fostered children before?  Yes  No When? \_\_\_\_\_

Have you ever adopted children before?  Yes  No

If yes, with what agency? \_\_\_\_\_ Years served \_\_\_\_\_

Are you a Day Care Provider?  Yes  No

If yes, please provide a license number \_\_\_\_\_

Please provide related education, training or personal experience working with Foster children or the child welfare system. \_\_\_\_\_

**Applicant #2**

Have you ever fostered children before?  Yes  No When? \_\_\_\_\_

Have you ever adopted children before?  Yes  No

If yes, with what agency? \_\_\_\_\_ Years served \_\_\_\_\_

Are you a Day Care Provider?  Yes  No

If yes, please provide a license number \_\_\_\_\_

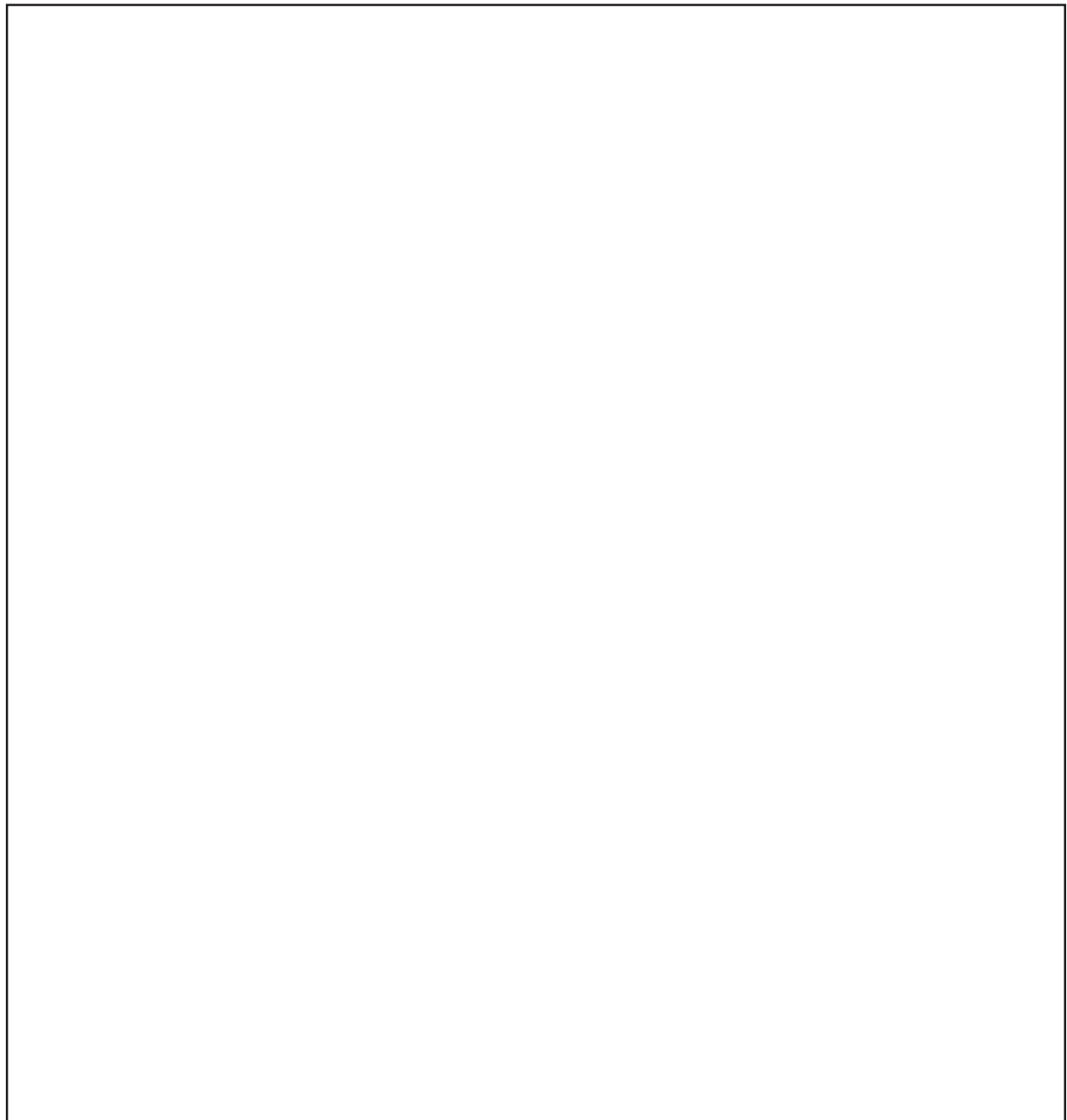
Please provide related education, training or personal experience working with Foster children or the child welfare system. \_\_\_\_\_



**Household members currently living in home (relatives, boarders, etc.)**

Name	DOB	Relationship	School/Grade/Occupation	Social Security

**Description of living arrangements. *Please provide a sketch and pictures of your home.***



# Financial History – Income/Expenses Worksheet

## Monthly Income

	Amount	Source
Wages		
SSI		
TANF		
Child Support		
Borders		
Rental Properties		
Retirement Accounts		
Stocks or Bonds		
Total Amount		

Are you on public assistance?  Yes  No If yes, please explain. \_\_\_\_\_

## Monthly Expenses

Item	Amount
Rent/Mortgage	
Food	
Electric	
Gas	
Oil	
Water	
Clothing	
Home Insurance	
Life Insurance	
Auto Insurance	
Car Loan	
Fuel	
Credit Cards	
_____	_____
_____	_____
Medical Expenses	
Cable/Interne	
Child Support	
Entertainment	
Phone (Land line and cell)	
Household Expenses	
Debt/Bankruptcy Payments	
Total Expenses	

## Name and Address

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Income and Expense Summary

Total Monthly Income \_\_\_\_\_

Total Monthly Expenses \_\_\_\_\_

### NOTE

Please attach a copy of the following documents:

Lease/Mortgage, two consecutive pay stubs,

SSI, Disability, W-2, 1040, Social Security

Retirement, or a letter from your employer.

If you are receiving subsidy payments for any

child in your household, please include this in

your income section as well. **Your application**

**cannot be processed without this information**

**and failure to provide this documentation will**

**be cause for denial of certification.**

*If applicant has ever applied for bankruptcy or been in a foreclosure, please provide documentation that it has been satisfied or the current payment information.*

# Homeowners/Auto Insurance Verification

## Applicant #1

### Home Owners

Name of Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

### Renters Insurance

Name of Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

### Auto Insurance

Do not own a car

Type of Car: Make \_\_\_\_\_ Model \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

*If you do not own your home and are renting, we suggest you consider applying for renters insurance.*

*Please provide a copy of your driver's license and auto registration.*

Please sign one:

I verify that my coverage is current and I will maintain coverage as long as I am certified as a resource parent with Lutheran Children and Family Service.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please attach a copy of your Home Owners and Auto insurance to this form and return.*

I verify that I am a renter and do not have home insurance at this time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Applicant #2

### Auto Insurance

Do not own a car

Type of Car: Make \_\_\_\_\_ Model \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

*If you do not own your home and are renting, we suggest you consider applying for renters insurance.*

*Please provide a copy of your driver's license and auto registration.*

Please sign one:

I verify that my coverage is current and I will maintain coverage as long as I am certified as a resource parent with Lutheran Children and Family Service.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please attach a copy of your Home Owners and Auto insurance to this form and return.*

I verify that I am a renter and do not have home insurance at this time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Disclosure Statements

All Applicants and any individuals 14 and older residing in the applicants' home must complete and return the attached Disclosure Statements. The parent or legal guardian of anyone 14-18 years old residing in the household also must sign the disclosure statement on behalf of the minor. The disclosure statement signifies that the applicant has provided accurate information and understands the responsibility to notify the agency of changes in clearance information for themselves and other household members 14 and older, as well as any changes in household composition.

I/WE UNDERSTAND THAT, BY SUBMITTING THIS APPLICATION PERMISSION IS GIVEN TO LUTHERAN CHILDREN AND FAMILY SERVICE TO SEND REFERENCE LETTERS TO THOSE INDIVIDUALS LISTED WITHIN, INCLUDING MY CLERGY AND PHYSICIAN(S). I/WE CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE AND FALSIFIED STATEMENTS MAY BE GROUNDS FOR NON-ACCEPTANCE/CLOSURE. I/WE ALSO UNDERSTAND THAT LUTHERAN CHILDREN AND FAMILY SERVICE WILL INITIATE A POLICE AND CHILD ABUSE BACKGROUND CHECK IN REGARDS TO THIS APPLICATION FOR ALL ADULT MEMBERS OF MY HOUSEHOLD, OVER THE AGE OF 14 YEARS. I/WE ALSO UNDERSTAND THAT ALL HOUSEHOLD MEMBERS 18 AND OLDER MUST SUBMIT A CURRENT FBI CLEARANCE. I/WE ALSO UNDERSTAND THAT LUTHERAN CHILDREN AND FAMILY SERVICE MAY REQUIRE A SIGNED CONSENT TO OBTAIN A CURRENT CREDIT REPORT.

Signature of Applicant #1 \_\_\_\_\_

Signature of Applicant #2 \_\_\_\_\_

*This form is merely a statement of intent and can be withdrawn by the applicant(s) at any time.  
All information will be kept confidential. We reserve the right to refuse certification.*



**Medical form for adults – To be filled out by a physician**

To Examining Physician:

Our client has come to you in response to a request from our agency, Lutheran Children and Family Service for a complete report to his/her physical condition. It is important for us to know of any health factors which may interfere with this person's ability to raise a child from infancy to adulthood.

Name of Client \_\_\_\_\_ Date of Examination: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Lungs \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart \_\_\_\_\_

Results of Physical Examination \_\_\_\_\_

\_\_\_\_\_

Corrective Treatment Needed \_\_\_\_\_

\_\_\_\_\_

**Medical History of Patient**

Check and give dates when possible:

Asthma \_\_\_\_\_  Ear Disorders \_\_\_\_\_

Allergies \_\_\_\_\_  Tendency to colds \_\_\_\_\_

Epilepsy \_\_\_\_\_  Cancer \_\_\_\_\_

Pneumonia \_\_\_\_\_  Hepatitis \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_  Meningitis \_\_\_\_\_

Diabetes \_\_\_\_\_  Tuberculosis \_\_\_\_\_

Ulcers \_\_\_\_\_  Mental Illness \_\_\_\_\_

Heart Problems \_\_\_\_\_  Accidents \_\_\_\_\_

Other Medical Conditions \_\_\_\_\_

Operations \_\_\_\_\_

Comments on prognosis for continued health \_\_\_\_\_

\_\_\_\_\_

Is there any evidence for any other illnesses or disabilities which might limit this person's activity or make it impossible for him/her to care for a child for a number of years? \_\_\_\_\_

\_\_\_\_\_

Do you consider this person mentally, emotionally and physically competent to foster or adopt a child?

\_\_\_\_\_

Is this patient free from communicable disease? (MUST BE COMPLETED)

Tine Test Results \_\_\_\_\_ How long have you know this patient? \_\_\_\_\_

Additional comments (if any): \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Name (Printed) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone Number \_\_\_\_\_

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Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Lungs \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Heart \_\_\_\_\_

Results of Physical Examination \_\_\_\_\_

\_\_\_\_\_

Corrective Treatment Needed \_\_\_\_\_

\_\_\_\_\_

**Medical History of Patient**

Check and give dates when possible:

Asthma \_\_\_\_\_  Ear Disorders \_\_\_\_\_

Allergies \_\_\_\_\_  Tendency to colds \_\_\_\_\_

Epilepsy \_\_\_\_\_  Cancer \_\_\_\_\_

Pneumonia \_\_\_\_\_  Hepatitis \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_  Meningitis \_\_\_\_\_

Diabetes \_\_\_\_\_  Tuberculosis \_\_\_\_\_

Ulcers \_\_\_\_\_  Mental Illness \_\_\_\_\_

Heart Problems \_\_\_\_\_  Accidents \_\_\_\_\_

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Additional comments (if any): \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Physician's Name (Printed) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone Number \_\_\_\_\_