Connecticut Department of Children and Families
APPLICATION FOR FOSTER CARE LICENSE
DCF-047
6/17 (Rev.)

(Attach additional pages if necessary)

FOR DCF USE ONLY					
Type of Placement: ☐ Adoption ☐ Foster Care ☐ Fictive Kin ☐ Independent ☐ Relative ☐ Respite Caregiver					
REQUIRED Checks:	Check Completed?:				Assigned FASU SW:
Protective Services Checks	Yes	Date	Attached	Pending	
CMS Search	☐		☐	☐	DCF Office:
DMV	☐		☐	☐	Please Select DCF Office
LINK Search	☐		☐	☐	SW Phone:
Childcare License (OEC)	☐		☐	☐	

APPLICANTS TO COMPLETE PAGES 1-9

Parent #1			Parent #2		
LAST Name:	FIRST Name:	M:	LAST Name:	FIRST Name:	M:
Birth Name (if applicable):	AKA (if applicable):		Birth Name (if applicable):	AKA (if applicable):	
DOB:	Race: Please Select One		DOB:	Race: Please Select One	
Birth Place:	Religion, if any:		Birth Place:	Religion, if any:	
CT Driver's License #	Social Security #:		CT Driver's License #	Social Security #:	
Language(s):	Home Phone:		Language(s):	Home Phone:	
Work Phone:	Cell Phone:		Work Phone:	Cell Phone:	
E-mail:			E-mail:		
Military Service:	Duty Status:	Type of Discharge:	Military Service:	Duty Status:	Type of Discharge:
Address: (No. and Street):			City:	State: Connecticut	Zip:
How long have you lived at your current address?:			How long have you lived at your current address?:		

LIST PREVIOUS ADDRESSES IN THE LAST FIVE YEARS (If applicable)	
Parent #1	Parent #2

CURRENT MARRIAGE OR RELATIONSHP STATUS		
☐ Single ☐ Not currently married ☐ Widowed	☐ Divorced ☐ Divorce pending ☐ Married, but Separated	☐ Other relationship status, please explain:
Date of Current Marriage:	Date started living together (if not married):	

PREVIOUS MARRIAGES OR RELATIONSHP(S)	
Parent #1	Parent #2
1. Name of Previous partner (if applicable):	1. Name of Previous partner (if applicable):
Type of Previous relationship: ☐ Marriage ☐ Relationship	Type of Previous relationship: ☐ Marriage ☐ Relationship
From (enter dates): To:	From (enter dates): To:
Reason for ending the relationship: ☐ Death ☐ Divorce ☐ Separation	Reason for ending the relationship: ☐ Death ☐ Divorce ☐ Separation
2. Name of Previous partner (if applicable):	3. Name of Previous partner (if applicable):
Type of Previous relationship: ☐ Marriage ☐ Relationship	Type of Previous relationship: ☐ Marriage ☐ Relationship
From (enter dates): To:	From (enter dates): To:
Reason for ending the relationship: ☐ Death ☐ Divorce ☐ Separation	Reason for ending the relationship: ☐ Death ☐ Divorce ☐ Separation

EMPLOYMENT INFORMATION			
Parent #1		Parent #2	
Name of Employer:		Name of Employer:	
Date of Hire:	# of hours worked each week:	Date of Hire:	# of hours worked each week:
Position	Work Phone:	Position	Work Phone:
Do you have a Second Job?			
Name of Second Employer:		Name of Second Employer:	
Date of Hire:	# of hours worked each week:	Date of Hire:	# of hours worked each week:
Position	Work Phone:	Position	Work Phone:

EDUCATIONAL BACKGROUND	
Parent #1	Parent #2
Highest Grade Completed (including college):	Highest Grade Completed (including college):
Name of High School or Trade School:	Name of High School or Trade School:
Name of College or University:	Name of College or University:
If appropriate, which area of study?:	If appropriate, which area of study?:

EMERGENCY - In case of emergency, list at least TWO persons who can be contacted				
1. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:
2. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:
3. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:

OTHER ADULT MEMBERS OF HOUSEHOLD (Over the age of 18, if applicable)						
LAST Name:	FIRST Name:	Birth Name:	AKA:	DOB:	Relationship to Applicant:	Occupation:

CHILDREN LIVING IN THE HOUSEHOLD (Under the age of 18, if applicable)				
LAST Name:	FIRST Name:	DOB:	Name of School:	Grade:

CHILDREN NOT LIVING IN THE HOUSEHOLD WITH YOU (if applicable)				
LAST Name:	FIRST Name:	DOB:	Name of School:	Grade:

ADULT CHILDREN NOT LIVING IN THE HOUSEHOLD WITH YOU (if applicable)			
LAST Name:	FIRST Name:	DOB:	Occupation / Employer (if applicable)

FREQUENT VISITORS			
LAST Name:	FIRST Name:	DOB:	Address where they live?:

HOW DID YOU HEAR ABOUT FOSTER CARE OR ADOPTION? (Check all that apply)

☐ Newspaper ☐ Phone Book ☐ Radio ☐ Television ☐ Referral from a current Foster or Adoptive Parent

☐ Facebook ☐ Twitter ☐ Internet ☐ House of Worship ☐ Other:

Have you or anyone regularly residing in your home, or any substitute caregiver, previously applied or been licensed for foster care or adoption by the Department of Children and Families or any other state or private agency? ☐ Yes ☐ No

If "Yes" please specify when, where and the resulting action:

Are you, or have you been a licensed childcare, adoptive or any other out-of-home care provider by DCF or any other state or private agency? ☐ Yes ☐ No

If "Yes" please specify when, where and the resulting action:

Have you discussed foster care or adoption with every family member? ☐ Yes ☐ No

If "Yes" please explain how your family members feel about foster care or adoption?:

Please explain why you want to become a foster or adoptive parent:

Have you or any other family member experienced any major life changes in the past year? (i.e., death of a family member, marriage, divorce, birth of a child, adoption of a child, major illness, job loss, or significant financial crisis? ☐ Yes ☐ No

If "Yes" please explain:

In what type of home do you live? ☐ Single Family ☐ Apartment ☐ Mobile Home ☐ Townhouse/Condo ☐ Other:			
Do you own or rent your residence? ☐ Own ☐ Rent	Was your residence built before 1978? ☐ Yes ☐ No ☐ Don't know / Unsure		
Is your residence "lead-free"? ☐ Yes ☐ No ☐ Don't Know / Unsure			
If you rent, please provide the name and address of your landlord. Notification will be made to the landlord of you interest in fostering a child in your residence.			
Landlord's Name:	Landlords Phone #:	Landlords E-mail:	
Landlords Address: (No. and Street):	City:	State:	Zip:
How many rooms in your home?:	How many bedrooms?	On what floor do you sleep?	On what floor would your foster child sleep?
Do you have a pool, Jacuzzi, hot tub or water on your property? ☐ Yes ☐ No	Is your water supply public or from a well? ☐ Public ☐ Well		
If you have a well, has it been inspected by local town officials? ☐ Yes ☐ No	Do you have an auxiliary heating system? ☐ Yes ☐ No		
If "Yes", what type: ☐ Wood ☐ Coal ☐ Solar ☐ Propane ☐ Other, please explain:			
Are there any firearms or weapons such as, but not limited to, rifles, assault weapons, shot guns, hand guns, swords, machetes, cross bows or hunting traps on the property? ☐ Yes ☐ No. If "Yes" please explain:			
Does anyone in the home, or who regularly visits the home, own or use a firearm or weapon such as a rifle, assault weapon, shot gun, hand gun, sword, machete, cross bow, hunting traps? ☐ Yes ☐ No. If "Yes" please explain:			
If you answered "Yes" concerning weapons, do you have a federal, state or town permit for weapons ☐ Yes ☐ No			
If "Yes", what kind of permit?			
If "Yes", how and where are the weapons stored?			
PETS			
Do you have any pets in your home? ☐ Yes ☐ No	(If "No", you may skip the "Pets" section and proceed to "Household Members" below.)		
If 'Yes", please list the types of pet(s):			
How are the pets supervised?:			
Do all the cats and dogs have current vaccinations? ☐ Yes ☐ No	Do any of the pets exhibit aggressive behaviors? ☐ Yes ☐ No		
Have you ever had any involvement with police or animal control officer due to roaming, aggression or other behavior by your pet? ☐ Yes ☐ No			
Has your pet bitten anyone? ☐ Yes ☐ No If "Yes", please explain:			
Veterinarian's Name:	Veterinarian's Phone #:	Veterinarian's E-mail:	
Veterinarian's Address: (No. and Street):	City:	State: Connecticut	Zip:

ABOUT YOU AND YOUR HOUSEHOLD MEMBERS					
Has either applicant or anyone regularly residing in your home ever been arrested?: ☐ Yes ☐ No					
Has either applicant or anyone regularly residing in your home ever been convicted of a crime? ☐ Yes ☐ No					
If you have answered yes to either of the above two questions, please provide specific details:					
Name of Household Member	Charge	City	State	Date of Arrest	Status of Case

HAS APPLICANT OR ANYONE REGULARLY RESIDING IN YOUR HOME EVER BEEN:
Charged or convicted of injury or risk of injury to a minor or other similar offense against a minor?: ☐ Yes ☐ No
Charged or convicted of impairing the morals of a minor or other similar offense against a minor?: ☐ Yes ☐ No
Charged or convicted of a violent crime against a person or other similar offense?: ☐ Yes ☐ No
Charged or convicted of the possession, use or sale of controlled substances within the past five years?: ☐ Yes ☐ No
Charged or convicted of possessing and/or distributing child pornography or other similar offense?: ☐ Yes ☐ No
Charged or convicted of illegal use of a firearm or other similar offense?: ☐ Yes ☐ No
If you answered "Yes' to any of the questions listed above, please explained what happened and when:
Are you / they currently awaiting trial for any charges?: ☐ Yes ☐ No
Have you/they ever had a minor removed from your/their care or custody for reason related to child abuse or neglect?: ☐ Yes ☐ No
Have you/they ever had an allegation of child abuse or neglect substantiated; or have a current child abuse or neglect allegation pending for any reason, through any agency or court in any city, county, state, country? ☐ Yes ☐ No
Have you/they ever had an allegation of abuse or neglect made against you regarding a child or an elderly or disabled person in any state city, county, state, country? ☐ Yes ☐ No
Have you/they ever requested voluntary services from a child protection services agency in any city, county, state, country? ☐ Yes ☐ No
Have you/they ever been involved with proceedings in a probate court with regards to a child's custody or guardianship? ☐ Yes ☐ No
If you answered "Yes" to any of the above questions, please explain what happened and when:
Have you/they ever had any motor vehicle violations (including but not limited to speeding or driving while impaired)? ☐ Yes ☐ No. If "Yes", please explain:

Have you, your parents, your children or other household members experienced domestic violence including but not limited to acts of aggression; hearing or seeing violence in the home; threats of coercive control or controlling behaviors from a significant other, spouse or family member; or hitting, slapping, shoving, pushing, hair pulling, eye gouging, kicking, sexually assaulting, spitting or being threatened with a weapon?: ☐ Yes ☐ No. If "Yes", please explain the incident, type of violence and the parties involved:

Type of Violence /Incident	City where incident occurred	State Where incident occurred	Date of incident	Were Police Involved?:
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PSYCHOLOGICAL OR PSYCHIATRIC SERVICES

Has anyone in the household ever received psychological or psychiatric services either in-patient or out-patient for any period of time, at any time? (This includes depression, anxiety, etc.). ☐ Yes ☐ No. If "Yes", please describe:

MEDICATIONS Is anyone in the household currently taking any medications? ☐ Yes ☐ No. If "Yes", please list:

Name of Individual:	Medication / Dosage:	Purpose Prescribed:	Prescribing Doctor:

Has anyone in the household ever experienced an issue with illegal drugs, alcohol or prescription medication at any time in his or her life? ☐ Yes ☐ No

If yes, please select:
☐ Use of illegal drugs
☐ Use of medication other than as prescribed
☐ Received an intervention for substance use
☐ Experienced black outs/grey outs as a result of drinking

Please explain who, what, what happened and when:

REFERENCES

Please list the names of three (3) people who can provide references for you and your family. These must be people who have known you and your family for at least two years. Only one reference can be a relative. Only one reference can be a person who knows just one family or household member. The other references must know the entire family or have seen you (and your partner, if appropriate) interact with children.

If you have a school age child, one reference must be from your child's teacher or another community professional such as a pediatrician or member of the clergy who knows you and your child.

Please include the relationship of these people to you and your family; for example, sister, church friend, child's teacher, pediatrician, neighbor, etc.

1. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:
2. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:
3. Name:		Relationship:		
Work Phone:	Cell Phone:	Home Phone:		
Address: (No. and Street):		City:	State:	Zip:

FINANCIAL STATEMENT

(Please provide verification of your income, such as any pay stubs or your most recent federal income tax return, and documentation verifying the monthly expenses listed below.)

Parent #1		Parent #2	
Source of Income: ☐ Employment ☐ Unemployment ☐ Social Security ☐ Other (please explain):		Source of Income: ☐ Employment ☐ Unemployment ☐ Social Security ☐ Other (please explain):	
Monthly Amount:	Other Income? ☐ Yes ☐ No Is 'Yes", How much per month?	Monthly Amount:	Other Income? ☐ Yes ☐ No Is 'Yes", How much per month?

MONTHLY EXPENSES

Alimony:	
Child Support:	
Credit Card(s):	
Estimated Monthly Groceries:	
Insurance (car, renters/homeowners, health/medical/dental/vision):	
Loans (car payment, payday, etc.):	
Miscellaneous / Other Expenses:	
Monthly rent or mortgage:	
Property taxes (car/home/boat/motorcycle, etc.):	
Utility bills [electricity, water, oil/gas/heat, cable, telephone(s), etc.]:	
TOTAL MONTHLY EXPENSES:	$ 0.00

I/We understand that the first board and care payment for a foster child will arrive up to six weeks after placement. I/We can support the child during that time period. ☐ Yes ☐ No

FAMILY PHYSICIANS			
1. Patient Name:	Doctor:		
Address: (No. and Street):	City:	State:	Zip:
2. Patient Name:	Doctor (If different from above):		
Address: (No. and Street):	City:	State:	Zip:
3. Patient Name:	Doctor (If different from above):		
Address: (No. and Street):	City:	State:	Zip:
4. Patient Name:	Doctor (If different from above):		
Address: (No. and Street):	City:	State:	Zip:
5. Patient Name:	Doctor (If different from above):		
Address: (No. and Street):	City:	State:	Zip:

I/WE HEREBY APPLY TO BE LICENSED FOR:	
Type of Placement: ☐ Adoption ☐ Foster Care ☐ Fictive Kin ☐ Independent ☐ Relative Foster Care ☐ Respite Caregiver	
For no more than Children	At this time, I am / we are able to provider for: ☐ Birth-to-5 years ☐ 6 10 12 ☐ 13 to 18
I / We prefer: ☐ Male(s) ☐ Female(s) ☐ Either	I/We prefer ☐ siblings ☐ Legal Risk Adoption is okay ☐ Just Foster Care ☐ Unsure

AGREEMENT	Parent 1 Initials	Parent 2 Initials
I/we have received a copy and explanation of DCF licensing regulations. I/We understand their content and agree to abide by them.		
I/We will promptly notify DCF of any changes in my/our personal or family circumstances that might affect my/our licensing status, including, but not limited to, moving, death, marriage, birth, employment, health or number of persons living in my/our home.		
I/We understand that any false statement which I/we make on this application or on any other application material submitted for review will be grounds to deny or revoke a license.		

By signing below, I/we agree that I have been informed of my/our rights and responsibilities and DCF's responsibilities pursuant to the state and federal foster care statutes regulations and agree to abide by them.

Name of Parent 1	Signature of Parent 1	Date
Name of Parent 2	Signature of Parent 2	Date

NON-DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (24 U.S.C. §§2000d, *et seq.*), as amended; Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794); Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. §§6101, *et seq.*), and Connecticut state law, the Connecticut Department of Children and Families (DCF) does not discriminate on the basis of race, color, national origin, sexual orientation, disability or age in admission or access to, or treatment or employment in, its programs and activities.

If you have a complaint or concern related to discrimination, please contact the DCF Ombudsman at 505 Hudson Street, Hartford, Connecticut, 06106, telephone 860-550-6364 and email DCF.OMBUDSMAN@CT.GOV