Department of Children and Families APPLICATION TO RENEW A LICENSE FOR FOSTER CARE



DCF-425A 6/17 (Rev.) Renewal Date: Provider #: LBC:

FASU USE ONLY			Region: L	1 ∐ 2					
Type of License: Ger	eral Use	Adoption [Foster Care	☐ Fi	ictive Kin Independent	Rela	ative Re	espite Caregiver	
				ΕΛΙ	ЛILY				
	Dar	ont 1		IAN		Dare	ont 2		
Parent 1 Last Name: First Name:				Last Name:			Parent 2 First Name:		
Last Name.		r ir st rvanic.			Last Name.		i ii st ivaino.		
202					200		5.		
DOB:		Home Phone:			DOB:		Home Phone:		
Work Phone:		Cell Phone:			Work Phone:		Cell Phone:		
E-mail:					E-Mail:				
L-IIIaii.					E-IVIAII:				
Address: (No. and Street):					City		State	Zip	
Mailing Address (If differen	t from above	2):			City		Zip		
y (,					State		
			EMDI (OVA AERIT	I Information				
	Dlo	aso attach docum				ncome tay r	raturn)		
	Pare		nentation verifyii	ig your in	ncome (i.e., paycheck stub or income tax return) Parent #2				
Name of Employer:	1 arci	π ι			Name of Employer:				
rvanie or Employer.					Nume of Employer.				
Date of Hire:		# of hours worl	kad		Date of Hire:				
Date of Hire:		each week:	keu				# of hours worked each week:		
Position		Work Phone:			Position		Work Phone:		
Salary (Monthly):		Other Sources of Income?:			Salary (Monthly):		Other Sourc	es of Income?:	
Name of Second Employer	:				Name of Second Employer:		1		
					,				
Date of Hire:		# of hours worl	kod		Date of Hire:		# of hours worked		
Date of Tille.		each week:	KCU		Date of fille.		each week:		
					5 11				
Position		Work Phone:			Position		Work Phone:		
Salary (Monthly):		Other Sources of Income?:			Salary (Monthly):		Other Sources of Income?:		
		FOST	ER CHILDREN	CURREN	ITLY PLACED IN YOUR HOM	1E			
Last Name:	First Name):	DOB:	From V	Which DCF Office?:		Name of So	cial Worker:	
Last Namo	Firet Name	۸,	DOB: From \		Which DCF Office?:		Name of Social Worker:		
Last Name: First Name		e: DOB: From v		From which DCF Office?:		Name of Social Worker:			
Last Name: First Name:		: DOB: From		From V	Which DCF Office?:		Name of Social Worker:		
Lost Names DOS			DOD:	Erom 1	Which DCF Office?:		Name of Social Worker:		
Last Name: First Name:		; .	DOB: From \						
Last Name: First Name:		e: DOB: Froi		From V	om Which DCF Office?:		Name of Social Worker:		
				1			1		

	OTHER ADL	ULT MEMBERS OF HOUS	EHOLD (Ov	er the age of 18, if	applicable)		
	LAST Name:	FIRST Name	e:	DOB: Relation		nship to Foster Parents	
					†		
					+		
		1			+		
		<u> </u>			 		
		EDEOLIE	UT VICITOD	C			
	LAST Name:	FIRST Name	NT VISITOR:	DOB:	Polatio	onship to Foster Parents	
	LAST IVAILE.	I III JI IVani	.	DOD.	Kciatio	וואווף וח ו חצובו ג מובוויצ	
				<u> </u>			
					<u> </u>		
			PETS				
	, – –	No (If "No", you r	nay skip the	"Pets" section and	proceed to "Househ	hold Members" below.)	
If 'Yes", please list			1				
Do all the cats and	dogs have current vaccinations?	Yes No			gressive behaviors?	Yes No	
Bedroom # Loc	cated on what floor?	SLEEPING A Who Sleeps in th			# of Beds in room	Bed Size	
1	ated on what hoor:	Who Siceps in th	3100111		" Of Dead III Toolii	☐ Twin ☐ Queen ☐ King	
2						☐ Twin ☐ Queen ☐ King	
3						☐ Twin ☐ Queen ☐ King	
4						☐ Twin ☐ Queen ☐ King	
5						☐ Twin ☐ Queen ☐ King	
	any changes to the Home or Comp		since the last	t license was appro	ved, please explain		
Are you interested	in being placed on the Careline Lis	st for omorgoncy placomor		∕es □ No.			
If "Yes", for what A				_	eds do you have ava	ailable?	
Has/Is the applicant or anyone regularly residing in the home or any person with regular access to the home:							
Been arrested during the past two years?							
Awaiting trial for any violation of law? Yes No Been referred to DCF for protective services? Yes No							
If you answered "Yes" to any question above, please explain:							

NON-DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (42 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. §§12131 *et seq.*) and the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101 *et seq.*), the Connecticut Department of Children and Families (DCF) does not discriminate on the basis of race, color, national origin, disability or age in admission or access to, or treatment or employment in, its programs and activities.

The DCF Office of Diversity and Equity coordinates DCF's effort to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84, and 91) and U.S. Department of Justice regulations (28 C.F.R. Part 35) in implementing these federal laws.

Discrimination on the basis of age, ancestry, color, gender identity or expression, genetic information, intellectual disability, learning disability, marital status, physical disability (including blindness), prior conviction of a crime, pregnancy, present or past history of mental disability, national origin, race, religion, sex or sexual orientation is prohibited under the law of the State of Connecticut.

For further information about the DCF grievance procedures for resolution of discrimination complaints, contact the DCF Office of Diversity and Equity, 505 Hudson Street, Hartford, Connecticut, 06106-7107, telephone 860- 550-6303, TDD 860-550-6028 or 1-800-982-6373.

FOSTER PARENT COMMITMENT AND ACKNOWLEDGEMENT

I/We acknowledge that the use of abusive, neglectful, corporal, humiliating or frightening punishment and inappropriate restraints is strictly prohibited.

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 change of address, death, marriage, birth, employment, health and number of persons living in my home.

THE DEPARTMENT OF CHILDREN AND FAMILIES HAS MY/OUR PERMISSION TO CHECK ALL INFORMATION RELATED TO MY APPLICATION FOR LICENSE RENEWAL.

SIGNATURES						
Name of Parent 1	Signature of Parent 1	Date:				
Name of Parent 2	Signature of Parent 2					
Nume of Furence	Signature of Farcht 2					