DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Joint Court Ordered Kinship Care and Foster Care Application - Part A

Use of form: Use of this form is mandatory; its completion meets the requirements of s.48.57(3m) of the Wisconsin Statutes. This form must be used for all court ordered Kinship Care applicants. Personally identifiable information collected on this form is confidential and will be used for identification and determination of eligibility for a payment only. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Part A of this application shall be completed and provided to the agency prior to the initiation of Kinship Care payments. Part B of the Foster Care application must be completed within 45 days of your signature on Part A of this form. The application process for foster care includes providing a completed Part B of this application, meeting with agency staff for interviews, allowing a physical inspection of your home, and providing required information to complete background checks. Failure to complete all steps will result in termination of payment under Ch. DCF 58.08(1)(b). Admin. Code.

Complete Section I. for each child that you are requesting Kinship Care reimbursement. The application includes space for two caregivers, in the case that you have additional caregiver applicants, you may attach additional sections. The agency will also provide forms for background checks required for both the Kinship Care and Foster Care programs. For more information or for assistance filling out this form, please contact the person who provided this form to you.

I. CHILD IN PROVIDER'S CARE (LICENSURE REQUEST)

Name – Child 1 (Last, First, MI)	Birthdate	Social Security Number or date applied
Date of Court Order	eWiSACWIS Case Number	Court Case Number

☐ Yes ☐ No Does the child receive social security income (SSI) on his or her **own** behalf? If "Yes", he or she is ineligible for Kinship Care payment.	Last Grade Completed

☐ Yes ☐ No U.S Citizen	If the child is not a U.S. citizen, describe status:	Name of School

☐ Yes ☐ No Do you have guardianship of this child?	Type of Guardianship ☐ s. 48.977 Wis. Stats. ☐ s. 48.9795 Wis. Stats (includes Ch. 54) ☐ Other, please describe:

Ethnicity (Check at least one box and may check up to three boxes)

- ☐ White
- ☐ Black / African American
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian / Pacific Islander
- ☐ Other

☐ Yes ☐ No Does the child have health insurance?	If yes, type: ☐ Badgercare+ ☐ Private Health Insurance
Relationship to caregiver	Date began living with caregiver

Name – Parent 1 of Minor Relative	Social Security Number	Birthdate	Telephone Number – Home
Address – Street	City	State	Zip Code

Ethnic / Racial Group (Check one) ☐ Black (not of Hispanic origin) ☐ Asian or Pacific Islander (includes Indian Subcontinent origin) ☐ American Indian / Alaskan Native ☐ Hispanic (Mexican, Puerto Rican or other Spanish culture) ☐ White	Marital Status ☐ Married ☐ Never Married ☐ Separated ☐ Unknown ☐ Divorced

Employed? ☐ Yes ☐ No	Name – Employer

Address - Employer (Street, City, State, Zip Code)	Telephone Number

Wages Earned	Wages Paid
$	☐ Weekly ☐ Biweekly ☐ 2 x Month ☐ Monthly ☐ Other - ____________

Unearned Income

☐ Unemployment insurance - $ __________ per ________ ☐ SSI - $ __________

☐ SS Retirement - $ __________ per month ☐ SS Disability Insurance - $ __________

☐ Veteran's benefits - $ __________ per month ☐ Other income - $ __________ per ________

Name – Parent 2 of Minor Relative	Social Security Number	Birthdate	Telephone Number – Home
Address – Street	City	State	Zip Code

Ethnic / Racial Group (Check one)	Marital Status
☐ Black (not of Hispanic origin) ☐ American Indian / Alaskan Native ☐ White ☐ Asian or Pacific Islander (includes Indian Subcontinent origin) ☐ Hispanic (Mexican, Puerto Rican or other Spanish culture)	☐ Married ☐ Never Married ☐ Separated ☐ Unknown ☐ Divorced

Employed?	Name – Employer
☐ Yes ☐ No	

Address - Employer (Street, City, State, Zip Code)	Telephone Number

Wages Earned	Wages Paid
$	☐ Weekly ☐ Biweekly ☐ 2 x Month ☐ Monthly ☐ Other - ____________

Unearned Income

☐ Unemployment insurance - $ __________ per ________ ☐ SSI - $ __________

☐ SS Retirement - $ __________ per month ☐ SS Disability Insurance - $ __________

☐ Veteran's benefits - $ __________ per month ☐ Other income - $ __________ per ________

II. RELATIVE CAREGIVER(S)

DCF Ch. 58.02(2) Relative" means an adult who is the child's stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in- law, sister-in-law, first cousin, 2nd cousin, nephew, niece, aunt, uncle, step uncle, step aunt, or any person of a preceding generation as denoted by the prefix of grand, great or great-great, whether by blood, marriage or legal adoption, or the spouse of any person named in this subsection, even if the marriage is terminated by death or divorce.

CAREGIVER 1 Name (Last, First, MI)	Social Security Number	☐ Yes ☐ No Are you a Wisconsin resident? If "Yes", for how long?
Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell
Email Address	Driver's License Number and State	

☐ Yes ☐ No Are you a relative of the child? If "Yes", check applicable box below:	Check box for which side of the child's family you are related through ☐ Maternal ☐ Paternal

☐ Stepparent	☐ Brother	☐ Sister	☐ Stepsister
☐ Stepbrother	☐ Half-brother	☐ Half-sister	☐ brother-in-law
☐ Sister- in-law	☐ First Cousin	☐ Second Cousin	☐ Nephew
☐ Niece	☐ Aunt	☐ Uncle	☐ Step-uncle
☐ Step-aunt	☐ Grandfather	☐ Grandmother	☐ Great-grandfather
☐ Great-grandmother	☐ Great-uncle	☐ Great-aunt	☐ Great-great-aunt
☐ Great-great-uncle	☐Great-great grandfather	☐Great-great step uncle	☐Great-great step aunt

Current Address – Street	City	State	Zip Code

School District of the Caregiver's Residence

Mailing Address if Different Than Above

Previous Addresses for Last 5 Years (Including Out-of-State or Country)

Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code

Demographic Information of Caregiver

Birthdate	Gender ☐ Male ☐ Female	Social Security Number	☐ Yes ☐ No Hispanic or Latino / Latina

Ethnicity (Check at least one box and may check up to three boxes)

☐ White ☐ Asian
☐ Black / African-American ☐ Native Hawaiian / Pacific Islander
☐ American Indian / Alaskan Native ☐ Other

Birthplace	Weight	Height	Hair Color	Eye Color

Marital Status

☐ Single – never married ☐ Divorced
☐ Married – living together ☐ Widowed
☐ Married – but separated

Educational Level

_____ Enter highest level of education attained.

01 to 11 Grade level completed in primary / secondary school. Enter last grade completed.
12 High school diploma, GED or National External Diploma Program
13 Awarded Associate's Degree
14 Awarded Bachelor's Degree
15 Awarded Graduate Degree (Master's or higher)

16 Other credentials (degree, certificate, diploma, etc.)
98 No formal education

Current Employment Status
☐ Employed ☐ Unemployed ☐ Not in labor force (not looking for work, retired, disabled, etc.)

CAREGIVER 2 Name (Last, First, MI)	Social Security Number	☐ Yes ☐ No Are you a Wisconsin resident? If "Yes", for how long?

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell

Email Address	Driver's License Number and State
☐ Yes ☐ No Are you a relative of the child? If "Yes", check applicable box below:	Check box for which side of the child's family you are related through ☐ Maternal ☐ Paternal

☐ Stepparent	☐ Brother	☐ Sister	☐ Stepsister
☐ Stepbrother	☐ Half-brother	☐ Half-sister	☐ brother-in-law
☐ Sister- in-law	☐ First Cousin	☐ Second Cousin	☐ Nephew
☐ Niece	☐ Aunt	☐ Uncle	☐ Step-uncle
☐ Step-aunt	☐ Grandfather	☐ Grandmother	☐ Great-grandfather
☐ Great-grandmother	☐ Great-uncle	☐ Great-aunt	☐ Great-great-aunt
☐ Great-great-uncle	☐Great-great grandfather	☐Great-great step uncle	☐Great-great step aunt

Current Address – Street	City	State	Zip Code

Mailing Address if Different Than Above

Previous Addresses for Last 5 Years (Including Out-of-State or Country)

Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code

Demographic Information of Caregiver

Birthdate	Gender ☐ Male ☐ Female	Social Security Number	☐ Yes ☐ No Hispanic or Latino / Latina

Ethnicity (Check at least one box and may check up to three boxes)
☐ White ☐ Asian
☐ Black / African American ☐ Native Hawaiian / Pacific Islander
☐ American Indian / Alaskan Native ☐ Other

Birthplace	Weight	Height	Hair Color	Eye Color

Marital Status
☐ Single – never married ☐ Divorced
☐ Married – living together ☐ Widowed

☐ Married – but separated

Educational Level

____ Enter highest level of education attained.

01 to 11	Grade level completed in primary / secondary school. Enter last grade completed.
12	High school diploma, GED or National External Diploma Program
13	Awarded Associate's Degree
14	Awarded Bachelor's Degree
15	Awarded Graduate Degree (Master's or higher)
16	Other credentials (degree, certificate, diploma, etc.)
98	No formal education

Current Employment Status

☐ Employed ☐ Unemployed ☐ Not in labor force (not looking for work, retired, disabled, etc.)

III. OTHER ADULT MEMBERS IN THE HOUSEHOLD

1. Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?	
2. Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?	
3. Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?	
4. Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?	
5. Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?	

Narrative

IV. OTHER CHILDREN IN THE HOUSEHOLD

1. Name (Last, First, MI)	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?
2. Name (Last, First, MI)	Birthdate (mm/dd/yyyy)

Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?
3. Name (Last, First, MI)	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?
4. Name (Last, First, MI)	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?
5. Name (Last, First, MI)	Birthdate (mm/dd/yyyy)
Relationship to Relative Caregiver	☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?

Narrative

V. EMPLOYEES OF CAREGIVER RELATIVE WHO WOULD HAVE REGULAR CONTACT WITH CHILD

1. Name	Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street	City	State	Zip Code
☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?			
2. Name	Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street	City	State	Zip Code
☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?			
3. Name	Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street	City	State	Zip Code

☐ Yes ☐ No Wisconsin resident? If "Yes", for how long?

VI. KINSHIP CARE REFERRAL FOR CHILD SUPPORT SERVICES -DCF 58.04(2)(e)

CURRENT RELATIONSHIP OF CHILD'S PARENTS TO EACH OTHER

Relationship Status

☐ Married ☐ Divorced ☐ Separated with court order
☐ Never married ☐ Unknown ☐ Separated without court order

Date - If Ever Married (mm/dd/yyyy)	Place of Marriage (City, State)	
Child Support Order Currently in Effect? ☐ Yes ☐ No ☐ Unknown	Child Support Amount (If applicable) $ ____________ per ____________	Child Support Being Paid ☐ Yes - Regularly ☐ No ☐ Yes - Irregularly ☐ Unknown
Paternity Established ☐ Yes ☐ No ☐ Unknown	Who is responsible for the case? County State Tribe	Order for Medical Support in Effect? ☐ Yes ☐ No ☐ Unknown

Child Receiving Medical Assistance (MA)?

☐ Yes ☐ No ☐ Unknown If "Yes", provide the MA number (if known) ______________________________

VII. KINSHIP CARE GOOD CAUSE NOTICE-DCF 58.12(2)

Cooperation with Child Support means that you may have to do one or more of the following things:

1. Name the parent(s) of any child included in your application for Kinship Care and give information to help find the parent(s).
2. Help to obtain money owed to the child(ren) who receive Kinship Care.
3. Help to obtain any other money or property due to any child included in your application for Kinship Care.
4. Report to the child welfare agency any court-ordered or voluntary child support paid directly to you by the non-custodial parent(s).
5. You may have to go to either the child welfare agency or the child support agency to sign necessary papers or give necessary information.

Your cooperation with Child Support is important because it would help entitle the child(ren) in your care to:

1. Know who are the child's legally recognized parents.
2. Receive emotional and financial support from both parents.
3. Receive social security, pension, and inheritance rights from both parents.
4. Receive adequate medical support and family medical histories from both parents.

Despite these possible benefits, you may have a good reason for not cooperating. Such a reason is called "good cause." If you believe that cooperating would cause you or the child(ren) in your care serious physical or emotional harm or create other situations you think would be harmful, you may have "good cause" now or at any time in the future. If you do claim "good cause," you must provide supporting evidence as to why you should not be required to cooperate.

If you want to claim "good cause" for not cooperating, complete the next section of this form.

If you want to claim "good cause" for not cooperating, but the child welfare agency does not approve your claim, you will not be eligible for Kinship Care unless you begin to cooperate. If you do not agree with the "good cause" claim decision, you may be able to request an appeal of that decision. The worker determining the Kinship Care eligibility will be able to provide you with more information.

Leave this Section blank if you are not requesting Good Cause

VIII. KINSHIP CARE GOOD CAUSE CLAIM- DCF 58.12

For Refusing to Cooperate in Obtaining Child and / or Medical Support

The following are circumstances under which the county or tribal child welfare agency may find that you have "good cause" for not cooperating:

1. Your cooperation could result in physical or emotional harm to the child in your care.
2. Your cooperation could result in physical or emotional harm to you which is so serious it reduces your ability to care for the child adequately.
3. The child in your care was born as a result of incest or sexual assault.

If you claim "good cause" for one of the above reasons, you must provide evidence to support your claim. You have 20 days from the date you claim "good cause" to give the child welfare agency this evidence. More time can be approved for exceptional reasons. The following are examples of the kinds of evidence you can use to support "good cause."

1. Birth certificates or medical or law enforcement records that indicate that the child was conceived as the result of incest or sexual assault.
2. Court, medical, criminal, child protective services, social services, psychological or law enforcement records which indicate that the alleged or absent parent might inflict physical or emotional harm on you or the child.
3. Medical records which give your or the child's emotional health history and present health status; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of you or the child.
4. A sworn statement from individuals, including friends, neighbors, clergy, social workers and medical professionals who might have knowledge of circumstances which would help support your claim.
5. Any other supporting or corroborative evidence.

If you have no evidence to support your fear of physical harm, it may still be able to make a "good cause" determination after an investigation. The agency may decide to conduct an investigation of any good cause claim. You may be required to give information to help in that investigation. The absent parent(s) will not be contacted without your being told first.
The child welfare agency must decide within 45 days if you have "good cause" based on your evidence.
Kinship Care payments cannot be denied, delayed, reduced or discontinued pending a determination of "good cause."
You will be notified immediately of the agency's "good cause" determination. If "good cause" is not found, you will have 10 days to withdraw the claim and cooperate, withdraw your application or request that your case be closed, exclude allowable individuals from the application or case, or request any allowable appeal.

If you are found to have "good cause" for not cooperating, the child support agency will be notified of the decision and directed to:

1. Take no further action to establish paternity, collect child support or pursue third parties who may be liable for medical support; or
2. Attempt to establish paternity, collect child support, or pursue third parties who may be liable for medical support without your cooperation, if this can be done without risk to you or the child.

If you do not sign this official claim for "good cause" in the presence of the agency worker, you must have your signature notarized. Deliver this notice to the agency in person or send it by registered or certified mail.
If your evidence is not sufficient, the Kinship Care agency will tell you what other evidence is needed. They will give you reasonable help in obtaining the necessary evidence.

☐ I certify that my "good cause" claim is based on fact to the best of my knowledge. I understand that giving false information will cause this

claim to be denied. I have received a copy of this claim. I hereby claim "good cause" for the following reasons:

____

SIGNATURE - Relative Caregiver / Applicant | Date Signed

Name- Child Welfare Agency | Date Signed

VI. CONFIRMATION

I, the undersigned Caregiver, attest to the following:

- Neither I, any other adult resident of this household nor any employee who would have regular contact with the minor relative identified above, have any arrests or convictions which would adversely affect the minor relative or my ability to care for the minor relative identified above.
- I will assist the agency to the extent possible in referring the parents of the minor relative identified above to the child support agency.
- I will cooperate with the agency in this application process, the annual eligibility redetermination, including applying for any other financial assistance programs for which the minor relative identified above may be eligible.
- I will cooperate and meet with the agency to complete the foster care licensing process within 45 days of my signature below. I understand that if I do not complete the foster care licensing process with the agency in the next 45 days by providing a completed Part B of this application, meeting with agency staff for interviews, allowing a physical inspection of my home, and providing required information to complete background checks I will be found in non-compliance with s. 48.57(3m)(am)1.Wis. Stats. and Ch. DCF 58.04(1) Admin. Code and the agency will proceed with termination of payment under Ch. DCF 58.08(1)(b). Admin. Code.
- I understand that the Kinship Care funds I receive may not be used toward purchases in any liquor store; any casino, gambling casino, or gaming establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.
- I will notify the agency within five (days) of any of the following occurring:
  - The habitation of any other adult in my home and prior to employment of any person who would have regular contact with the minor relative in this application.
  - The child and I move to a new residence.
  - I, or a prospective employee, employee, prospective adult resident, or adult resident of my home is the subject an investigation or final substantiated finding that the person has abused or neglected a child.
  - The child has a new caregiver.
  - The child is no longer living with me.
  - The child is married.
  - The child entered the military.
  - The child is deceased.
  - The child graduated, completes, or drops out from a full-time, kindergarten to 12th grade educational program or its equivalent, and the child is 18 years old.
  - There is no longer an individualized education program (IEP) under s. 115.787, Stats., in effect for the child and the child is 18 years old.
  - I am no longer supporting the child.
  - The child's parent is residing with the child and I.
  - The child is placed outside my home under a court order, voluntary placement agreement under s. 48.63, Stats., or a voluntary transition–to–independent–living agreement.
  - The child is placed into my home under a court order or a voluntary transition–to–independent–living agreement.
  - I will contact the agency prior to or within five (5) working days after the minor relative for whom a Kinship Care payment is made leaves my home.

If someone other than the applicant(s) has assisted in completing this form, by signing below you acknowledge that it is exactly as stated by applicant(s).

SIGNATURE – Person Other Than Applicant(s) That Assisted in Completing Form	Relationship to Applicant(s)	Date Signed

I attest that the information provided above is truthful and accurate to the best of my knowledge.

SIGNATURE – Caregiver 1	Date Signed
SIGNATURE – Caregiver 2	Date Signed
SIGNATURE – Caregiver 3	Date Signed

Joint Court Ordered Kinship Care and Foster Care Application - Part B

Use of form: Use of this form is mandatory; its completion in conjunction with Part A meets the requirements of s.48.57(3m) of the Wisconsin Statutes. This form must be used for all court ordered Kinship Care applicants. Personally identifiable information collected on this form is confidential and will be used for identification and determination of eligibility for a payment only. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Part A of this application shall be completed and provided to the agency prior to the initiation of Kinship Care payments. Part B of the Foster Care application must be completed within 45 days of your signature on Part A of this form. The application process for foster care includes providing a completed Part B of this application, meeting with agency staff for interviews, allowing a physical inspection of your home, and providing required information to complete background checks. Failure to complete all steps will result in termination of payment under Ch. DCF 58.08(1)(b). Admin. Code.

The application includes space for two caregivers, in the case that you have additional caregiver applicants, you may attach additional sections. The agency will also provide forms for background checks required for both the Kinship Care and Foster Care programs. For more information or for assistance filling out this form, please contact the person who provided this form to you.

I. CAREGIVER(S)

CAREGIVER 1 Name (Last, First, MI)

General Health Status

☐ Yes ☐ No Do you have family medical insurance? If "Yes", provide the company name.

Describe your current health status and any conditions you receive or have received treatment for.

List current medications and reason for use.

List all hospitalizations, reasons, and dates.

Military Service

☐ Yes ☐ No Have you ever been in the military? If "Yes", which branch:

Date of Enlistment	Date of Discharge	Type of Discharge

Current Employment Status

☐ Employed ☐ Unemployed ☐ Not in labor force (not looking for work, retired, disabled, etc.)

Occupation / job title:

Current employer:

Employer address (Street, City, State, Zip Code):

Date employment began: Date employment began: Name of supervisor: Name of supervisor:

Duties:

☐ Yes ☐ No Do you have a retirement plan?

Working hours and days of week:

Employment History (Previous 10 years)

Employer	Position	Duties	Dates of Employment	Reason for Leaving

Current Income (Include all sources of public assistance or social security)

Total Monthly Income: $ ____________

☐ Child Support: $ ____________ ☐ Maintenance: $ ____________ ☐ Unemployment: $ ____________

☐ Adoption Assistance: $ ____________ ☐ Kinship Care: $ ____________ From which agency? ____________

☐ SSI: $ ____________ ☐ SSD: $ ____________ ☐ SSA: $ ____________

☐ Supplemental: $ ____________

Foster Care Licensing History

☐ Yes ☐ No Have you ever applied for or been granted a foster care or other child care license?

Name of Licensing Agency	Type	Date of Application	Period of Licensure	Closing Reason

☐ Yes ☐ No Have you ever had a license or certification revoked?
If "Yes", provide date, reason and revoked by which agency.

☐ Yes ☐ No Have you ever applied for adoption?
If "Yes", please elaborate.

CAREGIVER 2 Name (Last, First, MI)

General Health Status

☐ Yes ☐ No Do you have family medical insurance? If "Yes, provide company name.

Describe your current health status and any conditions you receive or have received treatment for.

List current medications and reason for use.

List all hospitalizations, reasons, and dates.

Military Service

☐ Yes ☐ No Have you ever been in the military? If "Yes", which branch:

Date of Enlistment	Date of Discharge	Type of Discharge

Current Employment Status

☐ Employed ☐ Unemployed ☐ Not in labor force (not looking for work, retired, disabled, etc.)

Occupation / job title:

Current employer:

Employer address (Street, City, State, Zip Code):

Date employment began:

Name of supervisor:

Duties:

☐ Yes ☐ No Do you have a retirement plan?

Working hours and days of week:

Employment History (Previous 10 years)

Employer	Position	Duties	Dates of Employment	Reason for Leaving

Current Income (Include all sources of public assistance or social security)

Total Monthly Income: $ ____________

☐ Child Support: $ ____________ ☐ Maintenance: $ ____________ ☐ Unemployment: $ ____________

☐ Adoption Assistance: $ ____________ ☐ Kinship Care: $ ____________

From which agency? ____________

☐ SSI: $ ____________ ☐ SSD: $ ____________ ☐ SSA: $ ____________

☐ Supplemental: $ ____________

Foster Care Licensing History

☐ Yes ☐ No Have you ever applied for or been granted a foster care or other child care license?

Name of Licensing Agency	Type	Date of Application	Period of Licensure	Closing Reason

☐ Yes ☐ No Have you ever had a license or certification revoked?
If "Yes", provide date, reason and revoked by which agency.

☐ Yes ☐ No Have you ever applied for adoption?
If "Yes", please elaborate.

II. HOUSEHOLD (Other non-caregiving adults and children)

List **ALL** of your biological and / or adopted children whether they live in your home or not.

Name – Last, First, MI (print)	Age	Gender	Birthdate (mm/dd/yr)	Lives in Home	For Those Living in the Home List Any Health Conditions and Medication
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	
		☐ M ☐ F		☐ Yes ☐ No	

List the names and information of **ALL OTHER** individuals living in your home.
☐ Check if no additional people live in your home.

Name – Last, First, MI (print)	Age	Gender	Birthdate (mm/dd/yr)	Social Security Number	WI Driver's License OR State ID No. (if 18 or older)	Relationship
		☐ M ☐ F				
		☐ M ☐ F				
		☐ M ☐ F				
		☐ M ☐ F				
		☐ M ☐ F				
		☐ M ☐ F				

☐ Yes ☐ No Do you have any pets?
If "Yes", what type and how many?

☐ Yes ☐ No Is the animal(s) up-to-date on vaccinations?

III. FINANCIAL

☐ Yes ☐ No Do you have homeowner's or renter's insurance?
If "Yes", provide company name and policy number.

Household Monthly Expenses

Rent or mortgage	$
Heat and utilities	$
Groceries	$
Recreation / entertainment	$
Transportation	$
Installment purchases	$
Savings	$
Clothing	$
Charitable contributions	$

Insurance premiums	$
Medical / dental	$
Household expenses	$
Education expenses	$
Other expenses	$
Total	$

IV. DESCRIPTION OF CURRENT RESIDENCE

Age of Home	Square Footage	Number of Bedrooms	Number of Bathrooms	Total Number of Rooms

Square Footage of Foster Youth Bedroom	Type of Home (House, apartment, duplex, mobile, town home)
Type of Plumbing / Septic	☐ Yes ☐ No Plumbing / septic up to code?
Type of Electrical	☐ Yes ☐ No Electrical up to code?
Type of Heating / Air Conditioning	☐ Yes ☐ No Heating / air conditioning up to code?

List any repairs that are needed to the home.

List any internal hazards (fireplaces, staircases, etc.).

List any external hazards (lakes, rivers, busy street, railroad tracks, etc.).

List any farm machinery, outbuilding, outside pool or other hazardous machinery.

List any firearms or other weapons in the home. Specify how they and any ammunition are stored.

V. CONFIRMATION

I, the undersigned Applicant, agree to adhere to the requirements set forth in Ch. DCF 56 Admin. Code.

If someone other than the applicant(s) has assisted in completing this form, by signing below you acknowledge that it is exactly as stated by applicant(s).

SIGNATURE – Person Other Than Applicant(s) That Assisted In Completing Form	Relationship to Applicant(s)	Date Signed

I attest that the information provided above is truthful and accurate to the best of my knowledge.

SIGNATURE – Caregiver 1	Date Signed
SIGNATURE – Caregiver 2	Date Signed
SIGNATURE – Caregiver 3	Date Signed

ST. CROIX TRIBAL HEALTH AND HUMAN SERVICES
CONSENT TO BACKGROUND CHECK

I, ______________________________, hereby consent for St. Croix Tribal Health and Human Services to conduct the following background checks on my behalf: FBI Fingerprint Based/Adam Walsh, Department of Justice, Criminal Bureau,Sex Offender, Child Protective Services, school reports on applicant(s) children/children in the applicant(s) care, as well as any background checks via local law enforcement.

I authorize and request that all organizations provide information to St. Croix Tribal Health and Human Services to assist them in assessing my capacity to appropriately and competently carry out the duties and responsibilities of foster parents/out-of-home placement provider/kinship care relative, per Wisconsin Administrative Rule 48, 58 and St. Croix Tribal Indian Child Welfare safety requirements.

I authorize the release of any reports including home studies, law enforcement reports,school reports, and data as available to assess for the applicant(s) ability to care for placement children.

I hereby release St. Croix, it's divisions, affiliates, and enterprises and anyone acting on it's behalf from any and all claims or liabilities of any nature arising from or related to the preparation of the information contained in the criminal background reports, and the disclosures of such information for the application purpose.

I understand that this information will be kept confidential and will be available only to St. Croix Tribal Health and Human Services Family Department staff directly involved in assessing applicants.

______________________________________ ____________________________
First Name, Middle Name, Last Name (print) Date of Birth

____
Social Security Number

______________________________________ ____________________________
Signature Date Signed

______________________________________ ____________________________
Witness Date Signed

For foster care applicants and guardianship caregivers:

School District(s) ____

Local Law Enforcement Agency ____

Other Agencies: ____

BACKGROUND INFORMATION DISCLOSURE (BID)

This form is required under the provisions of Wis. Stat. § 48.685 and Wis. Admin. Code § DCF 12.03. Pursuant to Wis. Stat. § 48.685 and Wis. Admin. Code § DCF 12.03, this form must be completed prior to licensure, employment or non-client residency and is only valid for 120 days. Failure to comply may result in a denial or revocation of your license; or denial or termination of your employment or contract.

Providing your social security number is voluntary. However, not providing it could delay the background check process. The personal information you provide may be used for secondary purposes [Privacy Law, Wis. Stat. §15.04(1)(m)].

PLEASE PRINT OR TYPE YOUR ANSWERS. ATTACH ADDITIONAL PAGES IF NEEDED.

Check the box that applies to you.

☐ Current or Prospective Employee / Contractor
☐ Applicant for a license (including continuation or renewal)
☐ Non-Client Resident (10 years of age and older)
☐ Other – Specify:

Name – (First and Middle)	Name – (Last)	Position Title (If applicable)

Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)

Race	Social Security Number(s)
☐ American Indian or Alaskan Native ☐ Black ☐ Unknown ☐ Asian or Pacific Islander ☐ White	

Home Address	City	State	Zip Code

Name and address of Potential Employer or Licensing Agency.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, county, local, military, and tribal courts? Have you ever been convicted of another offense such as a municipal ordinance violation or a civil offense under a local ordinance? ➢ If **Yes**, list each pending charge or conviction, when it occurred, the date or arrest and conviction if applicable, and the city and state where the court is located. You may be asked to supply additional information including certified copy of the judgment of conviction, a copy of the criminal complaint or any other relevant court or police documents.	☐	☐
2. Were you ever adjudicated delinquent by a court of law, including tribal court, before your 18th birthday, for a crime or other offense such as a municipal ordinance violation or a civil offense under a local ordinance? ➢ If **Yes,** list each crime or offense, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Are you currently under community supervision by a state, federal or tribal agency (i.e. probation, extended supervision or parole)? ➢ If **Yes**, provide the name, address and phone number of the agency.	☐	☐

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
4. Are you currently, or have you ever been, required to be registered on a state, tribal or national sex offender registry? ➢ If **Yes**, explain, including the location, reason for registration and length of time required to be registered.	☐	☐
5. Are you currently the subject of a child abuse or neglect investigation by a government or regulatory agency? ➢ If **Yes**, explain and provide the name of the agency conducting the investigation.	☐	☐
6. Has any government or regulatory agency (other than the police) ever found that you abused or neglected a child? ➢ If **Yes**, explain, including when and where it happened and the name of the agency that made the finding.	☐	☐
7. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
8. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
9. Has any government or regulatory agency (other than the police) ever found that you abused an elderly person? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
10. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ➢ If **Yes**, explain, including credential name, limitations or restrictions, and time period.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➢ If **Yes,** explain, including when and where it happened and the reason.	☐	☐
3. Have you been discharged from a branch of the U.S. Armed Forces, including any reserve component? ➢ If yes, indicate the year of discharge: ______ ➢ Attach a copy of your DD214 if you were discharged within the last 3 years.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	YES	NO
4. Have you resided outside of Wisconsin in the last 5 years? ➢ If **Yes**, list each state and the dates you lived there.	☐	☐
5. Have you had a caregiver background check done within the last 4 years? ➢ If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.	☐	☐
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services or the Department Children and Families, a county department, a private child placing agency, school board or tribe? ➢ If **Yes**, list the review date, the result, the agency that conducted the review and attach a copy of the review decision.	☐	☐

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law that the information provided above is truthful and accurate to the best of my knowledge. I understand that knowingly providing false information or omitting information may result in a forfeiture and other sanctions as provided by law.

SIGNATURE	Date Signed