

CENTRE COUNTY CHILDREN & YOUTH SERVICES
420 Holmes Street
Bellefonte, PA 16823
814.355.6755 Phone
814.355.6939 Fax

RESOURCE FAMILY APPLICATION

Applicant 1

Full Name: _____ DOB: _____ Maiden/Other Name(s): _____

Social Security #: _____ Driver's License #: _____ Class: _____

E-mail Address: _____ Expiration Date: _____

Cell Phone #: _____

Marital Status: Married Single Divorced Widowed Separated Alternative Lifestyle

Race/Ethnicity
 Check All That Apply: Am. Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander White

Hispanic: Yes No

Applicant 2

Full Name: _____ DOB: _____ Maiden/Other Name(s): _____

Social Security #: _____ Driver's License #: _____ Class: _____

E-mail Address: _____ Expiration Date: _____

Cell Phone #: _____

Marital Status: Married Single Divorced Widowed Separated Alternative Lifestyle

Race/Ethnicity
 Check All That Apply: Am. Indian/Alaskan Native Asian Black/African American Native Hawaiian/Other Pacific Islander White

Hispanic: Yes No

CHILDREN

Name of Child	DOB	Social Security #	School/Grade or Occupation	Address (if not at home)

OTHER HOUSEHOLD MEMBERS

Name	DOB	Social Security #	Relationship	School/Grade or Occupation

RESIDENCE INFORMATION

Address: _____ Phone #: _____

_____ Township: _____

County: _____

Length of Time at this address: _____ Own
 Rent: _____
Landlord's Name

Water Supply: Municipal _____
 Private well _____
Landlord's Phone #

Circle one:
Homeowner's / Renter's Insurance Agency: _____ Policy #: _____

Effective Dates of Insurance Policy Coverage: _____

Directions to Residence:

SCHOOL INFORMATION

Local Elementary School: _____ Distance to School: _____

Local Junior High/Middle School: _____ Distance to School: _____

Local High School: _____ Distance to School: _____

VEHICLE INFORMATION

Vehicle 1

Make & Model: _____ Vehicle Passenger Capacity: _____

Inspection Date: _____ Vehicle Registration Date: _____

Vehicle 2

Make & Model: _____ Vehicle Passenger Capacity: _____

Inspection Date: _____ Vehicle Registration Date: _____

Vehicle 3

Make & Model: _____ Vehicle Passenger Capacity: _____

Inspection Date: _____ Vehicle Registration Date: _____

Car Insurance Company: _____ Policy #: _____

Is automobile available at all times? Yes No

EMPLOYMENT INFORMATION

Does anyone in your family receive any form of public assistance? Yes (Answer questions) Cash Assistance ACCESS Card
 No Food Stamps Subsidized Housing

Applicant 1

Name of Employer: _____ Position: _____
 Address: _____ Hours of Work: _____
 _____ Length of Employment: _____
 Phone #: _____ Gross Monthly Income: _____ Verified by: Pay Stub
 Tax Return

Work Responsibilities: _____

Previous Employers	Date of Employment (From - To)	Position / Work Responsibilities	Reason For Ending Employment

Applicant 2

Name of Employer: _____ Position: _____
 Address: _____ Hours of Work: _____
 _____ Length of Employment: _____
 Phone #: _____ Gross Monthly Income: _____ Verified by: Pay Stub
 Tax Return

Work Responsibilities: _____

Previous Employers	Date of Employment (From - To)	Position / Work Responsibilities	Reason For Ending Employment

MARITAL / RELATIONSHIP INFORMATION

Date of Marriage: _____ Location: _____
 (if applicable) (county & state)

Date of Co-Habitation: _____
 (if applicable)

Applicant 1

Have you ever filed for or completed divorce proceedings? Yes No

Date of Marriage: _____ Date of Divorce: _____

Name of Former Spouse: _____
 Location of Divorce _____
 (county & state)

Applicant 2

Have you ever filed for or completed divorce proceedings? Yes No

Date of Marriage: _____ Date of Divorce: _____

Name of Former Spouse: _____
 Location of Divorce _____
 (county & state)

PHYSICAL HEALTH INFORMATION

Type of Medical Insurance for Applicants: _____ Policy Number: _____

Type of Medical Insurance for Children: _____ Policy Number: _____

Family Physician: _____ Family Dentist: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Please list any serious illnesses that you or your children have had:

Name of Person	Illness	Date of Illness	Explanation of Illness

MENTAL HEALTH INFORMATION

Applicant 1

Have you ever received mental health services? Yes (Answer questions) No

Where: _____

Circumstances: _____

Diagnosis & Treatment: _____

Do you smoke? Yes No

Do you drink alcohol? Yes Frequency: _____
 No

Do you use illegal drugs? Yes No

Have you ever received treatment for drug or alcohol abuse? Yes No

Applicant 2

Have you ever received mental health services? Yes (Answer questions) No

Where: _____

Circumstances: _____

Diagnosis & Treatment: _____

Do you smoke? Yes No

Do you drink alcohol? Yes Frequency: _____
 No

Do you use illegal drugs? Yes No

Have you ever received treatment for drug or alcohol abuse? Yes No

LEGAL ISSUES

Has anyone living in your home ever been arrested? Yes No

Nature of Offense: _____

Date: _____ Location: _____
(municipality, city, state)

Has anyone living in your home ever been charged with a crime? Yes No

Nature of Offense: _____

Date: _____ Location: _____
(municipality, city, state)

Has anyone living in your home ever been convicted of a crime? Yes No

Nature of Offense: _____

Date: _____ Location: _____
(municipality, city, state)

Has anyone living in your home ever filed for a Protection From Abuse Order (PFA)? Yes No

If yes, what was the legal name
of the person at the time of filing: _____

Date of order: _____ Location where order was filed: _____
(municipality, city, state)

Has anyone ever filed a PFA on anyone living in your home? Yes No

If yes, what was the legal name
of the person at the time of filing: _____

Date of order: _____ Location where order was filed: _____
(municipality, city, state)

Has either applicant, at any time, filed for Bankruptcy (Chapter 7, 11, 12, 13)? Yes No

If yes, what was the legal name
of the person at the time of filing: _____

Date of order: _____ Location where order was filed: _____
(municipality, city, state)

Reason for filing bankruptcy? _____

Has the bankruptcy been satisfied? Yes When? _____ No When do you anticipate it being satisfied? _____

FOSTER/ADOPTIVE CHILD PREFERENCE(S)

Age Range Preference: (Check all that apply) 0-2 Years 3-5 Years 6-12 Years 12-18 Years No Preference

Gender: (Check all that apply) Female Male Siblings: Yes No

Race Preference: Yes: What? _____ No

OTHER

Have you cared for a foster child before? Yes No If Yes: Time Period: _____

Agency: _____

Address: _____

Have you adopted a child before? Yes No If Yes: Date of Finalization: _____

Agency: _____

Address: _____

Have you applied to other agencies to become a foster or adoptive parent? Yes No If Yes: Agency: _____

Address: _____

Do you have experience with children? Yes (Explain Below) No

Why do you wish to become a resource parent?

Applicant 1:

Applicant 2:

REFERENCES

Please list six individuals who have known you at least two years and will provide personal references. List no more than two relatives. Parents should not be listed as references. Please do not use individuals who do not know both applicants.

Name	Address	How Long Known?	Phone Number

YOU WILL BE REQUESTED TO PROVIDE ALL DOCUMENTATION TO VERIFY INFORMATION ON THIS APPLICATION

Centre County CYS reserves the right to request additional financial statements (i.e. the first two pages of the 1040/1099 Income Tax statement from the previous year, periodic employment verification, etc.). Centre County CYS will also require an enhanced State Police background check. Please note that Centre County CYS may also contact employers, adult children, schools, or other person(s) whom we may need to verify information provided on this application.

I/We have completed this application and the facts contained herein are true and correct to the best of my/our knowledge, information and belief. I/We verify that false statements herein are subject to the penalties 19 PA C.S. §4904 relating to unsworn falsification to authorities. I/We further understand that any falsification of information stated above will disqualify me from becoming a Resource Family.

Applicant 1

Date

Applicant 2

Date