Information is relating to

**FFA INFORMATION:**

|  |  |
| --- | --- |
| FFA NAME: | *Angels of Grace Foster Family Agency* |
| FFA LICENSE #: | 107207207 | Date Resource Home Approved: |  |

**GENERAL IDENTIFICATION:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Social Security #: |  |
| Driver’s License #: |  | Ethnicity: |  |
| Gender: |  | Marital Status: |  |
| Street Address: |  |
| City: |  | State: |  | Zip Code: |  |
| Mailing Address (if different): |  |
| Primary Phone #: |  | Message Phone #: |  |
| Employer Name: |  | Phone #: |  |

**SPOUSE INFORMATION:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Social Security #: |  |
| Driver’s License #: |  | Ethnicity: |  |
| Gender: |  | Marital Status: |  |
| Street Address: |  |
| City: |  | State: |  | Zip Code: |  |
| Employer Name: |  | Phone #: |  |

**BACK UP CONTACT PERSON**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Phone #: |  |

**CHARACTERISTICS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age Range Preference: | From:       | To:       | Total Capacity: |  |
| Gender Preference: | [ ]  Male | [ ]  Female | [ ]  Both |
| Emergency Shelter: | [ ]  Yes | [ ]  No | [ ]  Unknown |
| Child Care Plan: | [ ]  Yes | [ ]  No | [ ]  Unknown |
| In Home Visits Allowed: | [ ]  Yes | [ ]  No | [ ]  Unknown |
| Transportation Provided | [ ]  Yes | [ ]  No | [ ]  Unknown |
| Public transportation: | [ ]  Yes | [ ]  No | [ ]  Unknown |
| Language: |  | Religion: |  |
| Type of Population Served: |  |
| Environmental Factor/Pets: |  |

**EDUCATION PROVIDERS/SCHOOLS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| School Unified: | [ ]  Fresno | [ ]  Clovis | [ ]  Central | [ ]  Selma | [ ]  Other |
| Elementary School: |  |
| Middle School |  |
| High School |  |

**CHILDREN IN THE HOME UNDER 18 YEARS OF AGE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Gender: |  |
| Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Gender: |  |
| Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Gender: |  |
| Relationship: |  |

**OTHER ADULTS IN THE HOME**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Gender: |  |
| Relationship: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Initial: |  | Last Name: |  |
| Date of Birth: |  | Gender: |  |
| Relationship: |  |

**PAYEE INFORMATION:**

|  |  |
| --- | --- |
| Name: |  |
| Street Address: |  |
| City: |  | State: |  | Zip Code: |  |
| Phone #: |  | Contact Person: |  |

**ADDITIONAL INFORMATION:**

|  |
| --- |
| An agency representative has verified that this foster parent has a Carbon Monoxide Detector in this certified home and that it is in good working order? |
|  | [ ]  Yes [x]  No |
| This foster home is willing and/or wanting to take placement of children ages 0-3. The certified foster parents have completed the required Safe Sleep & Abusive Head Trauma Training. |
|  | [ ]  Yes [x]  No | Training was completed on: |       |

|  |
| --- |
| **FOR DSS OFFICE USE ONLY** |
| CWS/CMS Background clearance on the below mentioned revealed concerns. These concerns must be addressed in the Family Evaluation Report. \* A copy of the Family Evaluation Report must be provided whenever there is CWS/CMS history. |
|  |  |
| Name of Care Giver: |       | Date of Birth: |       |  |
|  |  |
| Name of Care Giver: |       | Date of Birth: |       |  |
|  |  |  |  |
| CWS/CMS Concerns:  |       |  |
|  |
| Family Evaluation Needed:  | [ ]  Yes | [ ]  No |