



## Foster or Adoptive Parent Application

**Instructions: Complete *all* sections of the application. If you have any questions about how to complete the application, please call us. For sections of the application that do not apply to you or your family, simply mark N/A. Please print all information.**

<b>I am/We are interested in:</b>	<b>Foster Care Foster to Adopt Adoption Kinship</b>
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**Foster Care and Foster to Adopt** are for families wanting to provide temporary care for children aged 0-17 until they are reunified with their birth family. **Matched Adoption** families must be willing to fill the need of children legally free for adoption (usually children age 6+ and siblings sets/groups). **Kinship** families care for children they are related to or whom they know well and have been approved by CPS as a kinship placement.

<b>Applicant Information</b>	<b>Applicant 1 Full Name:</b>		<b>DOB:</b>
	<b>Applicant 2 Full Name:</b>		<b>DOB:</b>
	<b>Street Address:</b>		
	<b>City:</b>	<b>Zip:</b>	<b>County:</b>
	<b>Length of time at Current Residence</b> ____ Years ____ Months		<b>Type of Housing</b> <input type="checkbox"/> Home <input type="checkbox"/> Apartment
	<b>Cell # (Applicant 1)</b>		<b>Cell # (Applicant 2)</b>
	<b>Work # (Applicant 1)</b>		<b>Work # (Applicant 2)</b>
	<b>Email Address (Applicant 1):</b>		
	<b>Email Address (Applicant 2):</b>		
<b>How did you hear about ACH Child and Family Services?</b>			
<b>What is your motivation to become a foster or adoptive parent?</b>			
<b>If applying for Kinship, information for CPS worker?</b>	Worker name: Contact #: Email Address:		
<b>Home Information</b>	<input type="checkbox"/> Rent <input type="checkbox"/> Own # of bedrooms in your home: Square feet of each bedroom: Room 1:           sq. ft. Room 2:           sq. ft. Room 3:           sq. ft. Room 4:           sq. ft. Room 5:           sq. ft.		
<b>Child Information</b>	# of children in your home: Age/gender of child(ren) in home Child 1 Age:                      Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Child 2 Age:                      Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Child 3 Age:                      Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Child 4 Age:                      Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Child 5 Age:                      Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		

**Have you experienced any major life change(s) in the last year?**  Yes  No  
 (Example: adoption/birth of a child, marriage, divorce, major medical procedure or diagnosis, fertility treatment (IUI, IVF), move to a new state, death of a loved one, etc.)

**If you have experienced a major life change in the last year, please explain in detail:**

	Applicant 1	Applicant 2
<b>Full Name</b>		
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
<b>Other names (nicknames, past names, maiden name)?</b>		
<b>Are you a US Citizen?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Place of Birth</b>		
<b>Race/Ethnicity</b>		
<b>Native American Heritage</b> Are you a registered member of any Native American tribe? If Yes, specify tribe and registration number.	<input type="checkbox"/> Yes <input type="checkbox"/> No Tribe: Registration Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No Tribe: Registration Number:
<b>Highest Level of Education (Include name of school, year graduated and degree received):</b>	Highest level: <input type="checkbox"/> High School <input type="checkbox"/> College Name of school: Year graduated: Degree received:	Highest level: <input type="checkbox"/> High School <input type="checkbox"/> College Name of school: Year graduated: Degree received:
<b>Describe any other training or educational achievements</b>		
<b>Employment</b>	Name of employer: Job title: Length at Current Employer ____ Years ____ Months	Name of employer: Job title: Length at Current Employer ____ Years ____ Months
<b>Yearly Gross Salary</b>		
<b>Medical Information</b>	List any medications you are taking and purpose:  List all current medical diagnoses:  List all past medical diagnoses:	List any medications you are taking and purpose:  List all current medical diagnoses:  List all past medical diagnoses:
<b>Residency Information</b>	Have you lived outside of Texas during the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give state and dates of past residency:	Have you lived outside of Texas during the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please give state and dates of past residency:

<b>Health Insurance Information</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Insurance company name:	<input type="checkbox"/> Yes <input type="checkbox"/> No Insurance company name:
<b>Marriage Information</b>	Date: Place (City, County, and State):	

<b>Previous Marriages</b> (Please use back, if needed)		
	<b>Applicant 1</b>	<b>Applicant 2</b>
<b>Number of Previous Marriages</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
<b>Marriage #1</b>	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:
<b>Marriage #2</b>	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:
<b>Marriage #3</b>	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:
<b>Marriage #4</b>	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:	Name of Previous Spouse: Date of Marriage: Place of Marriage (City, County and State): Date of Divorce/Death: Reason for Divorce/Death:

**Previous Agency Information**

<b>Previous Agency</b>	Have you ever applied to or been licensed by another child-placing agency for foster care or adoption?
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	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been denied by a child-placing agency? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**If you answered Yes to either question above, please list all agencies to which you have applied and/or been denied starting with the most recent agency.**

<b>Child-Placing Agency #1</b>	Date of Licensure: Date of Closure: Name of Agency: Address of Agency:  Name of Agency Contact/Caseworker: Phone Number for Agency:  Reason for Leaving the Agency:
<b>Child-Placing Agency #2</b>	Date of Licensure: Date of Closure: Name of Agency: Address of Agency:  Name of Agency Contact/Caseworker: Phone Number for Agency:  Reason for Leaving the Agency:

### Child(ren) Information

List all minor children (living, deceased, at home, or away from home (e.g. college)).

<b>Child #1</b>	Name: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Date of Birth: Age: Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Lives in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, current address? Relationship to Parent #1: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted Relationship to Parent #2: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted
<b>Child #2</b>	Name: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Date of Birth: Age: Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Lives in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, current address? Relationship to Parent #1: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted Relationship to Parent #2: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted
<b>Child #3</b>	Name: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Date of Birth: Age: Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Lives in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, current address? Relationship to Parent #1: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted Relationship to Parent #2: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted

<b>Child #4</b>	Name: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other Date of Birth: Age: Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Lives in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, current address? Relationship to Parent #1: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted Relationship to Parent #2: <input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted
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**Do you have adult children?**  Yes  No  
 If Yes, provide information on children below.

<b>Adult Child #1</b>	Name: Age: Address: City: State: Zip Code: Phone number: E-mail address:
<b>Adult Child #2</b>	Name: Age: Address: City: State: Zip Code: Phone number: E-mail address:
<b>Adult Child #3</b>	Name: Age: Address: City: State: Zip Code: Phone number: E-mail address:
<b>Adult Child #4</b>	Name: Age: Address: City: State: Zip Code: Phone number: E-mail address:

RELIGION	Applicant 1	Applicant 2
<b>Religious Affiliation</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Religion/Denomination</b>		
<b>Church Address</b>		

MILITARY SERVICE	Applicant 1	Applicant 2
<b>Served or Currently Active?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Branch of Military</b>		
<b>Dates of Service</b>		
<b>Type of Discharge</b> (only applies to those no longer active - please provide copy of discharge)		

## CHARACTERISTICS OF THE CHILDREN YOU ARE INTERESTED IN CARING FOR

Note: Foster children and children adopted from foster care have all experienced trauma in the form of neglect and/or abuse. Each child has unique needs and difficulties. The children we serve all have grief and loss in their lives and require understanding caregivers.

<b>Number of Children:</b>	<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<b>Race/Ethnicity</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latinx <input type="checkbox"/> Other
<b>Age Range:</b>	<b>Are you willing/able to take a sibling group?</b>	

Children in foster care of all ages and from a variety of backgrounds have a wide range of behaviors and needs. Due to the trauma they have experienced, the majority of the children we serve have behavioral challenges such as mild to severe developmental delays and emotional needs. Please mark the characteristics below you are willing and able to work with to help foster children. Please understand you will receive additional training and support to do so.

<input type="checkbox"/> <b>Behavioral Challenges</b>	<input type="checkbox"/> <b>Emotional Needs</b>	<input type="checkbox"/> <b>Sexually Abused</b>
<input type="checkbox"/> <b>Developmental Delays</b>	<input type="checkbox"/> <b>Mental Retardation</b>	<input type="checkbox"/> <b>Visually Impaired</b>
<input type="checkbox"/> <b>Drug Exposed</b>	<input type="checkbox"/> <b>Minor Medical Needs</b>	<input type="checkbox"/> <b>Major Medical Needs</b>
<input type="checkbox"/> <b>Hearing Impaired</b>	<input type="checkbox"/> <b>Mobility Impaired</b>	<input type="checkbox"/> <b>Low IQ</b>
<input type="checkbox"/> <b>Neglected</b>	<input type="checkbox"/> <b>Other:</b>	

## PREVIOUS ADDRESS FOR LAST 10 YEARS FOR EACH APPLICANT

<b>Applicant 1</b>  List complete address in which you have lived during the past ten (10) years. Include dates at each address. Use back side, if needed.	1. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	
	2. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	
	3. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	
<b>Applicant 2</b>  List complete address in which you have lived during the past ten (10) years. Include dates at each address.	1. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	
	2. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	
	3. Previous Address:		
	City:	State:	Zip:
	Date moved in: ___/___/___	Date moved out: ___/___/___	

**List all household members (other than self and children):**

Other People Residing In Your Home:	Name	Age	Relationship
	1.	1.	1.
	2.	2.	2.
	3.	3.	3.
	4.	4.	4.
<b>Comments:</b>			
<p><b>Will any of the household members have any childcare responsibilities for the foster or adoptive children?</b>                      (Person must be at least 18 years of age to provide childcare for children in DFPS custody).  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>If Yes to household members providing childcare, please explain what kind of care and how frequent:</b></p>			

**HOME AND COMMUNITY**

<p><b>Any specific routes to your home or special instructions for getting to your home?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                      If Yes, please explain:</p>
<p><b>Do you live in a gated community?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>How far is the nearest hospital from your home (in miles)?</b></p>
<p><b>What type of water service do you use?</b> <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Well</p>
<p><b>What type of utilities do you use to cool and heat your home?</b>  <input type="checkbox"/> All electric  <input type="checkbox"/> Gas  <input type="checkbox"/> Gas and electric combo</p>
<p><b>If you listed gas as a utility above, is it?</b> <input type="checkbox"/> Natural <input type="checkbox"/> Propane  <b>Do you have a gas fireplace/stove or a gas starter in your fire place:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                      If Yes, the State of Texas requires an additional inspection of all gas heaters and/or fireplaces by a licensed technician. Please ask ACH for more information.</p>
<p><b>Do you have homeowners insurance on your home or renters insurance for you apartment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                      If Yes, please specify agency/company:</p>
<p><b>Do you have pets in your home?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Please list all pets in your home.	Name of Pet	Type of Pet: (canine, feline, etc.)	Date of most recent rabies vaccination	Indoor or outdoor pet?
Use separate sheet and attach, if more than the four listed here.	1.			<input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor
	2.			<input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor
	3.			<input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor
	4.			<input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor

## TRANSPORTATION

Do you have reliable transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please list all vehicles to be used to transport foster/adoptive children	Year	Make	Model	Condition
Do you have Liability and Personal Injury Protection Insurance on your vehicles? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you willing/able to transport foster children to all appointments (visits with birth family and other activities during regular weekday work hours)? <input type="checkbox"/> Yes <input type="checkbox"/> No				

## LEGAL INFORMATION

1. Has anyone in your household ever been charged, arrested, and/or convicted of a misdemeanor or felony, including domestic violence disturbance? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
2. Have any individuals who visit your home ever been charged, arrested, and/or convicted of a misdemeanor or felony, including domestic violence disturbance? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
3. Has any member of your household ever had any allegations, charges, or convictions against them for child abuse or neglect? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
4. Have any of your children been temporarily or permanently removed from your home by the courts or Child Protective Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
5. Have any individuals who VISIT your home ever had any allegations, charges or convictions against them for child abuse or neglect? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
6. Has your family had any police visits, 911 calls, including domestic violence disturbances, to your home that did not result in an arrest or citation in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
7. Has anyone in your home had any police involvement, 911 calls to your address including domestic violence disturbances that did not result in an arrest or citation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES" please explain in detail (use separate paper if more room needed and staple to application):
If you have biological children in your home, are you willing to utilize our model of care Trust-Based Relational Interventions (TBR <sup>I</sup> ) with not only our foster children but with your biological children as well? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> More information needed



## REFERENCES

### Required

- List all siblings for each applicant (biological, half-siblings, adopted siblings, and stepsiblings). Use a separate sheet if you have more siblings than spaces on the application.
- All of the following must be well acquainted with the applicants for 3+ years.
- List six (6) additional individuals/couples: two (2) relatives that are NOT siblings and who do NOT reside in your home, two (2) other adults, and at least two (2) from the following: clergy, neighbor(s), colleagues, school personnel or community members.

<b>Sibling Reference 1</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Sibling Reference 2</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Sibling Reference 3</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Sibling Reference 4</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Relative Reference 1</b> (Non-sibling and not living in the home)	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		

<b>Relative Reference 2</b> (Non-sibling and not living in the home)	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Friend Reference 1</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Friend Reference 2</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Clergy, Work Colleague, School Personnel, Neighbor, or Community Reference 1</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		
<b>Clergy, Work Colleague, School Personnel, Neighbor, or Community Reference 2</b>	Name:		
	Address:		
	City:	State:	Zip:
	Phone Number(s) with area codes		
	Home:	Cell:	
	Email Address:		
	Relationship:		

## Statement of Understanding

I hereby declare that the information provided by me in this Application for Foster Care or Adoption is true, accurate, and complete to the best of my knowledge. I give permission for any of this information to be verified. I give my consent for any agency, employers, company, friends, or family to be contacted. I agree to allow ACH Staff access to my personal computer and mobile phone for assessment purposes. I acknowledge my understanding ACH Child and Family Services reserve, the right to decline any prospective foster or adoptive parents during any part of the licensing process. I also understand I may decide not to continue with the process at any time during the licensing process, as well.

\_\_\_\_\_  
Signature of Applicant 1

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant 2

\_\_\_\_\_  
Date

Please return the **completed** application to **ACH Child and Family Services** in person, or by mail, fax, or Email:

### By Mail:

ACH Child and Family Services  
ATTN: Foster Care/Adoption Recruitment Department  
3712 Wichita Street  
Fort Worth, TX 76119

### By Fax:

817-887-3390

### By Email:

[fosteradopt@ACHservices.org](mailto:fosteradopt@ACHservices.org)

**Please note:** If your application is turned in incomplete, we will have to request additional information which may delay the processing of your application. Please be sure to submit your SAFE Questionnaire(s), background check forms, and copies of your driver's license and social security card along with your application to be processed in a timely manner.