# CHOSEN TREATMENT FOSTER PARENT APPLICATION

This application has sections that contain a variety of questions. Please pay careful attention to each question and respond with as much detail as possible. You will notice this application requests information pertaining to both you and your parenting partner.

If you have any questions, please contact us at:

Baptist Family & Children's Services
7161A Columbia Gateway Drive
Columbia, MD 21046
410-872-1050 or 800-621-8834
E-mail: bhyppolite@baptistfamily.org
Website: www.baptistfamily.org

| | Primary Treatment Parent | Secondary Treatment Parent |
|---|---|---|

| | | |
|---|---|---|
| Full Name:<br>(First, Middle & Last) | | |
| D.O.B.: | | |
| Address: | | |
| County: | | |
| No. of Years at Address: | | |
| If less than 5 years,<br>Previous Address | | |
| Home Phone: | | |
| Cell Phone: | | |
| Work Phone: | | |
| Email Address: | | |
| Best Time to Contact You: | | |
| Marital Status: | | |
| # of Years Married: | | |
| Birthplace: | | |
| Race: | | |
| Religion: | | |
| Social Security #: | | |

**LIST ALL OF YOUR CHILDREN (LIVING IN THE HOME AND/OR ELSEWHERE):**

| Name | Age | D.O.B. | Relationship | Where Living Now |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**OTHER ADULTS CURRENTLY LIVING IN THE HOME:**

| Name | D.O.B. | Relationship | Renting |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

| Primary Treatment Parent | Secondary Treatment Parent |
|---|---|

| | |
|---|---|
| Employer: | Employer: |
| Job Title: | Job Title: |
| Supervisor's Name: | Supervisor's Name: |
| Gross Annual Income: | Gross Annual Income: |
| Work Schedule: | Work Schedule: |
| Other Sources of Income: | Other Sources of Income: |
| How long have you held this job?: | How long have you held this job?: |
| If less than three years, prior employer: | If less than three years, prior employer: |
| Last Grade/ Degree Completed: | Last Grade/ Degree Completed: |
| Are you currently serving as a foster parent?<br>☐ Yes ☐ No | Are you currently serving as a foster parent?<br>☐ Yes ☐ No |
| **If Yes,** When:<br>How Long:<br>Agency Name:<br>Address:<br>Telephone #: | **If Yes,** When:<br>How Long:<br>Agency Name:<br>Address:<br>Telephone #: |
| Have you ever served as a foster parent?<br>☐ Yes ☐ No | Have you ever served as a foster parent?<br>☐ Yes ☐ No |
| **If Yes,** When:<br>How Long: | **If Yes,** When:<br>How Long: |
| Agency Name:<br>Address:<br>Telephone #: | Agency Name:<br>Address:<br>Telephone #: |
| Do you provide in-home family day care? ☐ Yes ☐ No | |
| What is your relationship to your parenting partner (if applicable)? | |
| How many bedrooms do you have available for foster children?<br>Are there beds available? ☐ Yes ☐ No | |

Why would you like to become a treatment foster parent?

Are you interested in adoption? ☐ Yes ☐ No ☐ Unsure

Special skills/interests/hobbies you could share with a foster child:

**With the understanding that CHOSEN typically receives referrals for teenagers, tell us about the child you are able to work with:**

Male ☐ Female ☐ Either ☐ Ages 8-12 ☐ Ages 13-21 ☐

Race of Child: _____

Any special needs you could meet (such as handicapping conditions, learning disabilities):

_____

_____

Being a CHOSEN parent means making a commitment to working with a child experiencing behavioral or emotional problems. Are you able to make that commitment? Yes ☐ No ☐

Have you or any member of your household ever been treated for an emotional problem? If yes, please explain: Yes ☐ No ☐

_____

_____

Do you have any friends or relatives who would like to be foster parents? If yes, list their names. Yes ☐ No ☐

_____

Would you be willing to provide respite to children of all ages in the CHOSEN Program? Yes ☐ No ☐

Do you have an operable car and telephone? Yes ☐ No ☐

Have you or anyone living in your home **ever** been arrested or charged with a violation of the law?

If yes, please explain. Yes ☐ No ☐

Anything else you would like to tell us about yourself or your family?

**Please read carefully:**

**I hereby certify that this information is true and correct to the best of my knowledge. I authorize investigation of all statements contained in this application. This information will be used as necessary in arriving at a decision for certification as a treatment foster parent. I also understand that I must provide all required documentation in a timely manner as I only have 120 days from the date of this application to complete the certification process.**

**Primary Treatment Parent**

Print: _____

Signature: _____ Date: _____

**Secondary Treatment Parent**

Print: _____

Signature: _____ Date: _____