

Karyn T. Lynch  
Director

**A LETTER TO PROSPECTIVE FOSTER PARENTS**

Dear Prospective Foster Parent,

Thank you for your recent call to inquire about becoming a Maryland foster parent. As you are aware, Maryland is actively seeking loving, temporary homes for children in our care. At the Maryland Department of Human Resources, we firmly believe that children thrive in loving homes, and we want all of our children to thrive.

When parents are unable or unwilling to care for their children, we as a community must find a safe and nurturing home for these children until their parents are able to resume the responsibility of providing a safe environment for them.

I am so pleased that you are considering opening your home to a child in need of your guidance and love. Foster parents fill a vital role by helping children get through the toughest times in their lives. When you become a foster parent, you will receive training and continuous support from the local Department of Social Services as well as the Maryland Foster Parent Association. You may contact the association's staff member Berniece Newman at 1-866-MDKIDS1.

Again, I appreciate your interest, and hope that you will encourage more good people like yourself to serve Maryland's children.

I look forward to demonstrating our commitment to you and as you provide care to the vulnerable children of Maryland.

Sincerely,

Brenda Donald, Secretary  
Maryland Department of Human Resources



Karyn T. Lynch  
Director

**VERIFICATION CHECKLIST**

Dear Prospective Foster/Adoptive Parent:

Thank you for your interest and desire to become a foster parent. In order to begin the next training the following verifications must be submitted:

- Resource Intake**
- Resource Home Application**
- Medical Exam Form and TB test/chest x-ray results or**
- Dates set for physical exams with physicians name**
- Proof of income (current 1040 and pay stub) and assets**
- Proof of Household Expenses (mortgage or rent statement)**
- Verification of Current Rabies Shots for your pet(s) (If you have a pet)**
- Birth Certificates (self and children)**
- Copy of Driver's License(s)**
- Copy of Marriage Certificate (if applicable)**
- Copies of Divorce Decree(s) (if applicable)**
- Copy of Military DD214 (if applicable)**
- Family Picture**
- Guardianship Statement (for adoptive families only)**
- Back-up Caregiver**

Additionally, the Fire Department will contact you to schedule a fire inspection; the original report from the inspection needs to be submitted to your Resource Home Worker. Please note: Application materials may be submitted in pieces or as a complete packet to Evandra Jackson, 805 Brightseat Road, Landover, MD 20785.



**Prince George's County**  
**Department of Social Services**



**Jack B. Johnson**  
 County Executive

Karen T. Lynch  
 Director

<p><b>For Restricted Applicants Only</b>                  Name of Foster Child: _____                  Name of Foster Care Worker: _____                  ROA/Other State/County Involved: _____</p>
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<b>Full Name Prospective Foster/Adoptive Parent #1 (Please Print)</b>		<b>Date of Birth</b>
<b>Full Name Prospective Foster/Adoptive Parent #2 (Please Print)</b>		<b>Date of Birth</b>
<b>Address, including city and zip code (Please Print)</b>		<b>Telephone Number</b>
	<b>Foster/Adoptive Parent #1</b>	<b>Foster/Adoptive Parent #2</b>
<b>Social Security Number</b>		
<b>Birth Place</b>		
<b>Citizenship</b>		
<b>Race</b>		
<b>Religious Identificaiton</b>		
<b>Physical Description</b>	Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Complexion : _____	Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Complexion : _____
<b>Education</b>	Highest Grade Completed _____ Last School _____ Other _____	Highest Grade Completed _____ Last School _____ Other _____
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Living with another adult?		



	<b>Foster/Adoptive Parent #1</b>	<b>Foster/Adoptive Parent #2</b>
<b>Marriage</b>	To whom (most recent previous marriage): _____ Date: _____ Terminated by: _____ Death                      Divorce Date: _____	To whom (most recent previous marriage): _____ Date: _____ Terminated by: _____ Death                      Divorce Date: _____

	To whom (most recent previous marriage): _____ Date: _____ Terminated by: _____ Death                      Divorce Date: _____	To whom (most recent previous marriage): _____ Date: _____ Terminated by: _____ Death                      Divorce Date: _____
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<b>Current Employment</b>	Employer: _____ Occupation: _____ Telephone: _____ How Long: _____ Yearly Salary: _____ Other Income: _____	Employer: _____ Occupation: _____ Telephone: _____ How Long: _____ Yearly Salary: _____ Other Income: _____
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<b>Previous Jobs (Include Dates)</b>		
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<b>Military Service/ Discharge Date</b>		
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<b>Civic &amp; Social Organizations of which you are a member</b>		
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<b>Hobbies, Abilities &amp; Special Talents</b>		
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Do you operate a Day Care Center? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number of years licensed?
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	<b>Location</b>	<b>Person(s) in home</b>	<b>Age</b>	<b>Sex</b>	<b>Relationship to Applicant</b>
Bedroom 1					
Bedroom 2					
Bedroom 3					
Bedroom 4					
Bedroom 5					

In which bedroom(s) would the foster/pre-adoptive child(ren) sleep?

What school(s) do your child(ren) currently attend?

Number of Adults living in your home/apartment:	Number of Children living in your home/apartment:
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Number of bedrooms in your home/apartment:
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Have you ever been a foster parent before? Yes No

If yes, when and where?

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Have you ever applied to or adopted a child? Yes No

If yes, when and where?

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What prompted you to call our office? Please select from one of the following categories.

- |                                     |                             |                             |
|-------------------------------------|-----------------------------|-----------------------------|
| 1.) Website                         | 2.) Wednesdays Child        | 3.) Hotline                 |
| 4.) Flyers/Posters                  | 5.) Fair                    | 6.) Church                  |
| 7.) Business                        | 8.) Adopt US Kids           | 9.) Long-time Interest      |
| 10.) One Church One Child           | 11.) Community Organization | 12.) Foster/Adoptive Parent |
| 13.) Met Recruiter (Location) _____ | 14.) Other _____            |                             |

Parenting experience and any additional comments:

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Have you or any members of your household ever been involved in a Child Protective Service investigation conducted by any local Department of Social Services in the State of Maryland and/or any other state?

Yes No

If yes, please explain:

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## PRELIMINARY BACKGROUND REVIEW

Before we begin the training and licensing process, it is required that the following questions be answered and the form signed. All applicants and co-applicants must each fill out one section. Include any criminal charges regardless of date or when it occurred.

<b>Foster/Adoptive Parent #1</b>		<b>Yes</b>	<b>No</b>
1.	Have you or any member of your household ever had a confirmed, indicated or substantiated finding of child abuse or neglect in any state?		
2.	Do you or any members of your household have a pending child abuse or neglect investigation?		
3.	Have you or any member of your household ever been arrested and/or convicted of a crime?		
4.	Have you or any members of your household had a history of drug and/or alcohol abuse?		
5.	Do you or any members of your household have a history of mental illness?		
<i>If yes to any of the above questions, please explain in detail on a separate sheet of paper.</i>			

<b>Foster/Adoptive Parent #2</b>		<b>Yes</b>	<b>No</b>
1.	Have you or any member of your household ever had a confirmed, indicated or substantiated finding of child abuse or neglect in any state?		
2.	Do you or any members of your household have a pending child abuse or neglect investigation?		
3.	Have you or any member of your household ever been arrested and/or convicted of a crime?		
4.	Have you or any members of your household had a history of drug and/or alcohol abuse?		
5.	Do you or any members of your household have a history of mental illness?		
<i>If yes to any of the above questions, please explain in detail on a separate sheet of paper.</i>			

<b>Placement Reference Checklist</b>			
Please indicate all categories of child(ren) for which your family is interested in providing care:			
<input type="checkbox"/>	Foster Care Placement	<input type="checkbox"/>	Pre-adoptive Placement
<input type="checkbox"/>	Infants (newborn to 18 months old)	<input type="checkbox"/>	Drug Exposed Infant
<input type="checkbox"/>	HIV Infant	<input type="checkbox"/>	Pre-school child (2 years to 5 years old)
<input type="checkbox"/>	Sibling group of 2 or more (newborn to 5 years old)	<input type="checkbox"/>	School-age child (6 years to 11 years old)
<input type="checkbox"/>	School-age sibling group of 2 or more children (6 years to 11 years old)	<input type="checkbox"/>	Teenager (12 years old to 18 years old)
<input type="checkbox"/>	Teenager sibling groups (12 years old to 18 years old)	<input type="checkbox"/>	Pregnant Teenager or Teenager with a child
<input type="checkbox"/>	A child with Attention Deficit Disorder (Hyperactivity)	<input type="checkbox"/>	A child with emotional problems
<input type="checkbox"/>	A child with mental retardation: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate	<input type="checkbox"/>	A developmentally delayed child
<input type="checkbox"/>	A developmentally delayed child		

**State of Maryland-Adoption Program**

**STATE OF MARYLAND – ADOPTION PROGRAM**

**Family Financial Statement**

<b>Applicant(s) Name(s):</b>	<b>Date:</b>
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**I. Income**

**Department Use Only – How Verified**

Monthly Earnings	Male	Female	Male	Female
Gross:				
Net:				
Child Support:				
Alimony:				
Benefits/Pensions:				
Other (specify)				
Other (specify)				

**II. Assets**

**Department Use Only – How Verified**

	Male	Female	Male	Female
Checking:				
Savings:				
Other (specify)				

**III. Expenses (combined, if married couple)**

**Department Use Only – How Verified**

Item	Monthly Expenses		Item	Monthly Expenses	
1. Housing a. First Mortgage	1a.		9. Medical	9.	
b. Second Mortgage	1b.		10. Entertainment	10.	
c. Rent	1c.		11. Contributions	11.	
d. Maintenance	1d.		12. Savings	12.	
2. Utilities a. Gas & Electric	2a.		13. Retirement/IRA	13.	
b. Heat	2b.		14. Child Support	14.	
c. Telephone	2c.		15. Education	15.	
d. Water	2d.		16. Credit Cards a.	16a.	
3. Auto Loans	3.		b.	16b.	
4. Auto Insurance	4.		c.	16c.	
5. Transportation	5.		17. Other Loans a.	17a.	
6. Food	6.		b.	17b.	
7. Clothing	7.				
8. Child Care	8.				







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**ADOPTIVE/FOSTER FAMILY MEDICAL REPORT**

**1. Date**

**2. Examining Physician:**

Mr. and/or Ms. \_\_\_\_\_ is/are applying to care for foster children. We need to be informed about any health problems within the household, the extent and significance of such problems in so far as they may affect the care and protection of children. This information is for confidential use.

**3. Please check the appropriate answers to the following questions. Explain all "NO" answers in the space provided below.**

	YES	NO
a. Are all members of the household free from acute or chronic disease (such as dermatitis, venereal disease, chronic respiratory infection, etc.) that might affect the health or development of children under care?		
b. In your opinion, are the members of the household free of serious nervous or emotional disorders that would affect the well-being of foster children.		
c. From your experience, do you believe the parents are physically and mentally capable of caring for children aged ___ to ___ in addition to of their own?		

**Explanation:**

**4. CHEST X-RAYS and/or TUBERCULIN TEST are required for ALL members of the household. Indicate dates given and results (Positive or Negative). These tests should have been done within the last three months. The local health office provides free x-ray services.**

Name of Household Member	Age	Chest X-Ray		Tuberculin Test	
		Month/Day/Year	+/-	Month/Day/Year	+/-

**5. Printed Name of Physician:**

**6. Signature:**

**7. Address:**

**8. The household has been under my care since**

Month:

Year:





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**MEDICAL APPOINTMENTS**

Please list the appointments you have scheduled for each family member's physical.

Please print all information.

Applicant(s): \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_

Date & Time of Appointment \_\_\_\_\_





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**GUARDIANSHIP STATEMENT**

Adoptive Family: \_\_\_\_\_

I/We have been made aware of Maryland's state requirement to appoint a guardian for my/our adopted child/children in the event of a debilitating accident, illness that renders me/us unable to provide proper care for the child/children or my/our untimely death.

Signatures: \_\_\_\_\_

Prospective Foster/Adoptive Parent #1

\_\_\_\_\_

Prospective Foster/Adoptive Parent #2

After careful consideration, I/we have chosen:

Name of Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age:

Marital Status:

Health:

**Guardian(s) agreement and signature(s):**

I/We agree to act as the guardian(s) for child/children of the above named foster/adoptive family. We concur with the accuracy of the information above and we fully accept the responsibility of overseeing the welfare of their child/children in the event that they are no longer able to do so.

Signatures: \_\_\_\_\_

Guardian

\_\_\_\_\_

Guardian





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**BACK-UP CAREGIVER**

In cases of emergencies, \_\_\_\_\_ has agreed to provide care  
for any child(ren) placed in my/our \_\_\_\_\_ care.

\_\_\_\_\_ understands that he/she must undergo Maryland, FBI and  
Child Protective Services clearances before being approved as an Emergency caregiver.

\_\_\_\_\_  
Foster/Adoptive Parent #1 Signature

\_\_\_\_\_  
Foster/Adoptive Parent #2 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

***For Office Use Only:***

**Maryland**  
Passed    Failed

**FBI**  
Passed    Failed

**CPS**  
Passed    Failed

Date Back-up Caregiver Approved: \_\_\_\_\_

