

Foster's Home For Children

Thank you for your inquiry concerning admittance to Sherwood and Myrtie Foster's Home for Children. Please find enclosed an Application for Admission. Note that applications will be held on a waiting list for **60 days only**.

- Please ensure the following are in your application packet:
 1. Completed application forms
 2. A current medical exam report
 3. A current dental exam report
 4. A current psychological evaluation (completed by a licensed psychologist)
 5. A guardianship form
 6. School transcript and current grades
 7. Educational testing (if any)
 8. Immunization records
 9. Copy of birth certificate
 10. Copy of social security card
 11. Court order
 12. Insurance information
 13. Proof of citizenship

Mail the above application packet to:

Foster's Home for Children
Attention: Vice President of Children's Services
P.O. Box 978
Stephenville, TX 76401

- Call to make an appointment with the Vice President of Children's Services for an initial interview and Home tour. (Phone #: 254-968-2143 Ext. 284 or e-mail derrick@fostershome.org)
- If an initial interview indicates that Foster's Home for Children is an appropriate fit for the child, a final interview will be conducted regarding placement.

Please call Foster's Home for Children with any questions concerning the application packet at the above number.

FOSTER'S HOME FOR CHILDREN APPLICATION FOR ADMISSION

Requirements for Psychological Evaluation:

A psychological evaluation is necessary for all applicants to Foster's Home for Children. Any psychologist who is licensed in the state of Texas may make the evaluation; results of the testing must then be sent to the Vice-President of Children's Services or the child's case manager at Foster's Home for Children, PO Box 978, Stephenville, TX 76401, for evaluation.

The evaluation must include:

1. A standard test of intelligence (such as WISC or Stanford-Binet.)
2. A test of academic achievement (such as WRAT or California Achievement Test.
3. A personality description (Roschach, T.A.T., etc.)
4. A personality inventory (California Test of Personality, Bell Adjustment Inventory, etc.)

Any expense incurred in completing these documents (e.g. testing, court orders, etc.) will be the expense of those persons making the application.

Requirements for Medical Examination:

A physical must be conducted within thirty 30 days of the date of the youth's admittance, or one will be done for you within thirty 30 days after the youth's admittance.

Requirements for Dental Examination:

A dental examination must be made within a sixty (60) day period prior to the admittance of the youth at Foster's Home, or one will be made for you within sixty (60) days after youth's admittance.

Requirements for Medication Forms:

All over the counter and prescribed medication will be in the care of the Family Teacher. A thirty-day supply of medication, labeled by the child's attending doctor, should be brought at time of placement.

Requirements for "Guardianship" Form:

If parents are divorced, a copy of the court order must accompany the application showing who has custody of the applicant.

Requirements for "School Records":

Please obtain a copy of child's transcript, immunization records, current grades, and any educational testing. Do not have the school send these to us, but instead have these available at the intake interview.

Guidelines for Parents of New Placements

Visitation

1. Parents must request a visit through the Children's Services Department.
2. A minimum of 3 days prior notice must be given.
3. Visits are approved and coordinated by the case manager, with final approval by the Vice President of Children's Services.
4. Each child's behavior is monitored closely by the staff. In certain instances an off-campus visit will not be permitted.
5. Pre-arranged visits by family on campus may be approved.
6. Transportation for the visit will be provided by the family of the youth.

Telephone Calls

1. All calls to the home are answered by the caregivers.
2. Permission must be granted by the caregivers before making long distance calls.
3. Youth are encouraged to write instead of call.
4. A youth may only make one call per week unless the youth's parents/legal guardians live in two separate households.

Communication

1. Parents, family and friends are encouraged to communicate regularly with their youth.
2. Parents are expected to remember their children with gifts and cards on special days and times during the year.

Vacations

1. Vacation plans are made by the youth's case manager.
2. All vacations are approved by the Vice President of Children's Services.

Important Notifications

1. Parents must notify Foster's Home Administration of any emergency **before** contacting the youth.
2. Parents must notify Foster's Home Administration of any change of address or phone number.

Please Remember

1. No weapons of any kind are allowed at Foster's Home.
2. No smoking is allowed.
3. No form of drugs, tobacco or medication should be left with the youth.
4. No personal TVs are permitted. Electronic devices permitted by case manager.
5. Youth may only bring a maximum of \$50. After one week at foster's Home, the youth may begin receiving money as a part of the Campus Allowance/Work program.
6. No personal cars or motorcycles permitted. A youth with a valid driver's license is allowed to drive campus vehicles with the permission of the Vice President of Children's Services.
7. Youth may bring bicycles.
8. No animals/pets permitted.
9. Checks for youth care must be made out to Foster's Home. The youth's name and purpose of the check must be written on the check.
10. Youth are not permitted to receive money as gifts, except on special occasions with the case manager's approval.

If at any time you feel your rights have been violated, contact the Vice President of Children's Services or President/CEO immediately

Foster's Home For Children

Intake Assessment

CURRENT CHILD SITUATION:

SAFETY: *Attaining physical, psychological, social, and moral safety.*

Date: _____

Name of Child: _____ Sex: (M) _____ (F) _____

Social Security Number: _____ Race: _____

Citizen/Non (circle) if non, please comment _____

Birth Date: _____ Place of Birth: _____ Age: _____

Address (number and street): _____

City: _____ State: _____ County: _____ Zip Code: _____

Telephone: (____) _____ Church Preference: _____

Referral Source: _____

I give permission for Foster's Home for Children to contact all necessary parties (physician/teacher/etc.) regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of my child, _____.

Parent/Guardian Signature: _____ Date: _____

EMOTION: *Managing emotion, acting intelligently, trading actions for words.*

Presenting Problems: (check all that apply)

- | | | |
|------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Very unhappy | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Temper outburst | <input type="checkbox"/> Disobedient | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Infantile | <input type="checkbox"/> Sexual trouble |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Mean to others | <input type="checkbox"/> School performance |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Destructive | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Trouble with the law | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Running away | <input type="checkbox"/> Soiled pants |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Head banging | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Distractible | <input type="checkbox"/> Rocking | <input type="checkbox"/> Sickly |
| <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Shy | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Peer conflict | <input type="checkbox"/> Strange thoughts | <input type="checkbox"/> Suicide talk/danger to self |
| <input type="checkbox"/> Phobic | <input type="checkbox"/> Runaways | <input type="checkbox"/> Danger to others |
| <input type="checkbox"/> Gang involvement | <input type="checkbox"/> Cruelty toward animals | <input type="checkbox"/> Poor adult relations |
| <input type="checkbox"/> Use of weapons | <input type="checkbox"/> Sexually active | <input type="checkbox"/> Alcohol/Drug use |
| <input type="checkbox"/> Gets along w/older children | <input type="checkbox"/> Gets along w/younger children | <input type="checkbox"/> other: _____ |

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PSYCHOLOGICAL SERVICES:

- | | |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. Provider _____
Problem _____
Dates of Services _____
Success/Failure _____ | 2. Provider _____
Problem _____
Dates of Services _____
Success/Failure _____ |
| 3. Provider _____
Problem _____
Dates of Services _____
Success/Failure _____ | 4. Provider _____
Problem _____
Dates of Services _____
Success/Failure _____ |

How long have these problems occurred? (Number of weeks, months, years)

What happened that makes you seek help at this time (reason for placement)? _____

Problems perceived to be: _____ very serious _____ serious _____ not serious

What are your expectations of your child in placement? _____

What changes would you like to see in your child in the future? _____

What changes would you like to see in yourself in the future? _____

What changes would you like to see in your family future? _____

How does the child handle stress? _____

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CHILD HEALTH INFORMATION (ALL INFORMATION REQUIRED)

Note all health problems the child has had or has now.

	Age/Dates		Age/Dates
<input type="checkbox"/> High fevers	_____	<input type="checkbox"/> Dental problems	_____
<input type="checkbox"/> Pneumonia	_____	<input type="checkbox"/> Weight problems	_____
<input type="checkbox"/> Flu	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Encephalitis	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Headaches	_____
<input type="checkbox"/> Convulsions	_____	<input type="checkbox"/> Stomach problems	_____
<input type="checkbox"/> Unconsciousness	_____	<input type="checkbox"/> Accident prone	_____
<input type="checkbox"/> Concussions	_____	<input type="checkbox"/> Anemia	_____
<input type="checkbox"/> Head injury	_____	<input type="checkbox"/> High or low Blood pressure	_____

<input type="checkbox"/> Fainting	_____	<input type="checkbox"/> Sinus problems	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Heart problems	_____
<input type="checkbox"/> Tonsils out	_____	<input type="checkbox"/> Hyperactivity	_____
<input type="checkbox"/> Vision problems	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Hearing problems	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Earaches	_____	<input type="checkbox"/> Other illnesses, etc.	_____
<input type="checkbox"/> Chicken pox	_____	(Explain)	
<input type="checkbox"/> Allergies	_____		

(Explain: Food, meds.)

Has the child ever been hospitalized (including psychiatric hospitalization or other placement outside the home)? Yes No

If yes, please explain.

Age	How long	Reason	Successful discharge (If no, explain)
_____	_____	_____	_____
_____	_____	_____	_____

Has child ever been seen by a medical specialist? Yes No

Age	How long	Reason
_____	_____	_____
_____	_____	_____

Is the child taking any prescribed medications? Yes No

Age	How long	Reason
_____	_____	_____
_____	_____	_____

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Has the child been tested for: Hepatitis B: _____ Results: _____
 AIDS: _____ Results: _____
 Other STDS: _____ Results: _____

List all psychiatric diagnosis the child has been given (prescribed meds, effectiveness:

Prescribed Medication	Effectiveness	Reactions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Primary Care Physician _____

DEVELOPMENTAL HISTORY

Planned for? Yes No
 Normal pregnancy? Yes No
 Overall health of mother during pregnancy, explain:

Length of pregnancy: _____
 Paternal support and acceptance: (explain)

BIRTH:

Full term: Yes No
 If premature, how early? _____
 Birth weight: _____ lbs. _____ oz.
 Type of delivery: Normal Cesarean
 Did mother abuse alcohol/drugs during pregnancy? Yes No

NEWBORN INFORMATION:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How Long
Irritability	_____	_____	_____
Vomiting	_____	_____	_____
Difficulty breathing	_____	_____	_____
Difficulty sleeping	_____	_____	_____
Convulsions/twitching	_____	_____	_____
Colic	_____	_____	_____
Normal weight gain	_____	_____	_____
Was child breast-fed	_____	_____	_____

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DEVELOPMENTAL MILESTONES:

Age at which child:

Sat up: _____

Crawled: _____

Walked: _____

Spoke single words: _____

Sentences: _____

Bladder trained: _____

Bowel trained: _____

Weaned: _____

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers:

- | | |
|------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Individual play | <input type="checkbox"/> Group play |
| <input type="checkbox"/> Competitive | <input type="checkbox"/> Cooperative |
| <input type="checkbox"/> Leadership role | <input type="checkbox"/> Follower |

Describe special habits, fears, or idiosyncrasies of the child:

FUTURE: *Trying new roles, moving forward, creating hope.*

EDUCATIONAL HISTORY:

Name of School	City/State	Dates attended:		Grades completed at this school
		From	To	
Preschool _____	_____	_____	_____	_____
Elementary _____	_____	_____	_____	_____
Junior high _____	_____	_____	_____	_____
High school _____	_____	_____	_____	_____

Types of classes: Regular Learning disability Continuation
 Emotionally Handicapped Opportunity Other

Did child skip a grade? Yes No Repeat a grade? Yes No
(If yes, when and how many years appropriate grade level at present time?)

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Did child have any specific learning difficulties? Yes No
 Has child ever had a tutor or other special help with schoolwork? Yes No
 Does child attend school on a regular basis? Yes No
 Does child appear motivated for school? Yes No
 Has child ever been suspended or expelled? Yes No
 Significant behavior problems? Yes No (Explain if yes)

IQ test Results: _____
 TAKS Results: _____

Does or did any member of the child's family have any problems with:

Reading Spelling Math Speech

ACADEMIC PERFORMANCE:

Highest grade on last report card? _____

Lowest grade on last report card? _____

Favorite subject? _____

Least favorite subject? _____

Does child participate in extracurricular activities? Yes No (explain)

In school, how many friends does the child have: a lot a few none

What are the child's educational aspirations?
 Quit school
 Graduate from high school (GED)
 Go to college/trade school
 Military

List child's special interest, hobbies, skills, and positive attributes:
 (Include clubs, part-time jobs, and social clubs)

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LOSS: *Feelings of grief and dealing with personal loss.*

CRIMINAL HISTORY

Has the child had difficulty with the police? Yes No (If yes, explain)

Has the child ever appeared in juvenile court? Yes No (If yes, explain)

Has/is the child ever been on probation? Yes No

From	To	Reason	Probation Officer
_____	_____	_____	_____
_____	_____	_____	_____

Has the child ever been in the custody of CPS? Yes No (if yes, explain)

ABUSE/NEGLECT HISTORY

Has the child ever been abused:

Physical Sexual Neglect Abandonment

Brief Discussion: _____

SAFETY: *Attaining physical, psychological, social, and moral safety.*

CURRENT FAMILY SITUATION:

MOTHER-Relationship to child: Natural parent Relative

Name: _____ Step-parent Adoptive parent

Occupation _____

Education _____ Religion _____

Employer _____ Income _____

Birthplace _____ Birth date _____

Age _____ SS# _____

Phone _____ Driver's License# _____

Address _____

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FATHER-Relationship to child _____ Natural parent _____ Relative
Name: _____ Step-parent _____ Adoptive parent

Occupation _____

Education _____ Religion _____

Employer _____ Income _____

Birthplace _____ Birth date _____

Age _____ SS # _____

Phone _____ Driver's License # _____

Address _____

Marital History of Parents:

Natural Parents: _____ Married When _____ Age _____

_____ Separated When _____

_____ Divorced When _____

_____ Deceased When _____

Step-parents: _____ Married When _____

If child is adopted:

Adoption source: _____

Reason and circumstances: _____

Age when child first in home, date of legal adoption: _____

Is the child entitled to: _____ SS _____ VA _____ Adoption Subsidy

_____ Disability _____ AFDC _____ Other

Is the applicant covered by any insurance? _____ Yes _____ No
(If yes, attach copy of front and back of card)

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Medical: Name of Company: _____

Address: _____

Street/PO Box City State Zip

Name of Holder: _____ SS# _____

Employer: _____

Policy Number: _____

Dental: Name of Company: _____

Address: _____

Street/PO Box City State Zip

Name of Holder: _____ SS# _____

Employer: _____

Policy Number: _____

LIVING ARRANGEMENTS:

Places

Dates

Number of moves in child's life _____

Was the child ever placed, boarded, or lived away from the family? _____ Yes _____ No

Explain: _____

Present Home _____ Renting _____ Buying _____

_____ House _____ Apartment _____

Does the child share a room with anyone else? _____ Yes _____ No

If yes, with whom? _____

If no, how long has he/she had own room? _____

What are the major families stresses at the present time, if any? _____

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What are the sources of family income? _____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Grade	Living at home	Drug Use	Treatment for Drug Use
_____ (Circle)							
1. _____							Bio/Step
2. _____							Bio/Step
3. _____							Bio/Step
4. _____							Bio/Step
5. _____							Bio/Step

Others living in the home (and their relationship): Other significant people in child's life:

- | | |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |

HEALTH OF FAMILY MEMBERS (EXCLUDING CHILD) and extended family including history of depression, self-destructive behavior, or legal problems:

Name	Relationship to child	Type of Illness	When Occurred	Length of Illness
1. _____				
2. _____				
3. _____				
4. _____				

Is there any history in the child's family of:

- Mental retardation Epilepsy Birth defects Schizophrenia
 (If yes, please explain)
- Diagnosed Disorder such as Bipolar, ADHD, etc.

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DENTIST STATEMENT

I certified that I have examined _____

On (date) _____ and find no adverse dental conditions, except:

EXCEPTIONS:

Dentist signature: _____ Date: _____

A dental check-up must be made prior to admittance to Foster's Home. If applicant has had a check-up within three months, these records will be considered current and acceptable.

DATE OF LAST DENTAL CHECK-UP WITHIN THREE MONTHS: _____

MEDICATION RECORDS

Please list the name of any medication _____ is taking and the reason. Write "none" if no medicine is being taken at this time.

Name of Medication: _____

Reason for Medication: _____

(Attach copies of all prescriptions)

Physician's signature

Date

No medication of any nature should be brought with the applicant to Foster's Home without a doctor's written prescription and recommendations. All medications must be prescribed within a 30-day period prior to the applicant's admittance.

Application Packet Checklist

_____ Birth Certificate	_____ Immunization Records
_____ Social Security Card	_____ School Records
_____ Insurance Information	_____ Application
_____ Court Order	_____ Psychological
_____ Physical Exam	_____ Medical Records
_____ Dental Records	_____ Guardianship

** Some information may not be applicable to all children.

Placement Interview Checklist:

_____ Original S.S. Card (not a copy)

_____ Proof of citizenship, e.g. green card (not a copy)

_____ Original Birth Certificate (not a copy)