

Minnesota Adoption and Child Foster Care Application

Instructions

To apply for a child foster care license and/or adoption home study, complete and send this form along with the [Minnesota Adoption and Foster Care Individual Fact Sheet \(DHS-4258B\)](#) for each applicant to your local county social service agency or a private child-placing agency.

LICENSING AGENCY	
TYPE OF APPLICATION <input type="radio"/> New application <input type="radio"/> Update <input type="radio"/> Renewal <input type="radio"/> Change of premises	APPLYING FOR <input type="checkbox"/> Foster care/adoption <input type="checkbox"/> Adoption
TYPE OF CHILD YOU ARE INTERESTED IN <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Either Age range _____ <input type="checkbox"/> Sibling group of up to _____ children <input type="checkbox"/> Specific child	FOR INTERNATIONAL ADOPTION ONLY INDICATE SPECIFIC COUNTRY OR AREA REQUESTED

Applicant 1

Tell us about you and where you live.

LAST NAME		FIRST NAME		MIDDLE NAME	FORMER NAMES
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single			
RACE <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White				ETHNICITY Hispanic <input type="radio"/> Yes <input type="radio"/> No	
CURRENT HOME (STREET) ADDRESS (and P.O.BOX if required for mail delivery)					APT. NUMBER
CITY				STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS		
TRIBAL AFFILIATION		LANGUAGES SPOKEN	RELIGION	EDUCATION	
AREAS OF SPECIALIZED EDUCATION		OCCUPATION	NUMBER OF HOURS IN A WORK WEEK	TYPICAL WORK SCHEDULE	

Have you lived at any other address in the last five year? No Yes If yes, complete below

Address 1			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Is there a second applicant in the home? No Yes If yes, complete the information below

Applicant 2

LAST NAME		FIRST NAME		MIDDLE NAME		FORMER NAMES	
SOCIAL SECURITY NUMBER		DATE OF BIRTH		MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single			
RACE <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White						ETHNICITY Hispanic <input type="radio"/> Yes <input type="radio"/> No	
CURRENT HOME (STREET) ADDRESS (and P.O. BOX if required for mail delivery)							APT. NUMBER
CITY						STATE	ZIP CODE
HOME PHONE NUMBER		WORK PHONE NUMBER		CELL PHONE NUMBER		EMAIL ADDRESS	
TRIBAL AFFILIATION		LANGUAGES SPOKEN		RELIGION		EDUCATION	
AREAS OF SPECIALIZED EDUCATION		OCCUPATION		NUMBER OF HOURS IN A WORK WEEK		TYPICAL WORK SCHEDULE	

Has this applicant lived at any other address in the last five years? No Yes If yes, complete below

Address 1			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Emergency evacuation plan

Emergency contact person: Name a person that would know how to contact you in case of emergency and/or evacuation.

NAME	PHONE NUMBER
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If an emergency evacuation of a home is necessary due to disaster, indicate the location where foster children would go:

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Do you have additional household members living in the home? No Yes

If yes, list all adults and children (not including foster children) living in the home below.

Household member 1			
LAST NAME		FIRST NAME	MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	
Household member 2			
LAST NAME		FIRST NAME	MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	

Household member 3		
LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD
Household member 4		
LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD
Household member 5		
LAST NAME	FIRST NAME	MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD

If you have more household members to report, please attach an additional piece of paper.

Home (Description of the home as it pertains to foster care of children)

SCHOOL DISTRICT IN WHICH HOME IS LOCATED	
Children placed in the home would attend the following schools	
ELEMENTARY	MIDDLE/JUNIOR HIGH
HIGH SCHOOL	SCHOOL TRANSPORTATION <input type="checkbox"/> Bus <input type="checkbox"/> Other _____
DOES APPLICANT HOME SCHOOL? <input type="radio"/> No <input type="radio"/> Yes – has applicant's home school plan been approved by the public school district? <input type="radio"/> Yes <input type="radio"/> No	
Does anyone smoke in the home? <input type="radio"/> No <input type="radio"/> Yes - fill in below	
WHO SMOKES IN THE HOME?	
WHAT IS YOUR PLAN TO PROVIDE A SMOKE-FREE ENVIRONMENT IN YOUR HOME, GARAGE, SURROUNDING AREA, AND CAR?	
Are there pets in the home? <input type="radio"/> No <input type="radio"/> Yes - fill in below	
WHAT TYPE(S) OF PETS?	
DO ANY PETS IN THE HOME POSE SAFETY CONCERNS? <input type="radio"/> Yes <input type="radio"/> No	DO PETS HAVE CURRENT VACCINATIONS? <input type="radio"/> Yes <input type="radio"/> No

Dwelling information (check all that apply)			
<input type="checkbox"/> Own <input type="checkbox"/> Rent	<input type="checkbox"/> Mobile home <input type="checkbox"/> Basement	<input type="checkbox"/> Single family house <input type="checkbox"/> Multi-unit (apartment building)	<input type="checkbox"/> Free standing solid fuel heating appliance
Sleeping arrangements (indicate where foster child will sleep)			
Bedroom floor/level	Occupants	Type of bed(s) Crib, single, double, bunk (if bunk, indicate upper -U or lower -L)	Storage space for personal possessions
1.			
2.			
3.			
4.			
LIST AREAS AND/OR ITEMS IN YOUR HOME THAT ARE LOCKED AND/OR INACCESSIBLE TO A FOSTER OR ADOPTED CHILD			

Experience with foster care and/or adoption, or any other licensing (including child care, adult foster care, etc.)

Have you ever applied, or worked with another foster care agency? No Yes - list all agencies (Minnesota and out-of-state)

Agency name	Address	Dates of involvement and outcomes

Are you currently or have you ever been licensed? No Yes - list all agencies (Minnesota and out-of-state)

TYPE OF LICENSE (check all that apply)		
<input type="checkbox"/> Family child care <input type="checkbox"/> 245D-HCBS	<input type="checkbox"/> Child foster care <input type="checkbox"/> Other	<input type="checkbox"/> Adult foster/community residential setting <input type="checkbox"/> Family adult day services
LICENSE NUMBER (if known)	COUNTY/AGENCY/STATE	EFFECTIVE DATES OF LICENSE (if known)

Have you ever had a Minnesota Department of Human Services (department) license denied or revoked, or been the subject of an unfavorable home study?

No Yes

EXPLAIN (include license type, denial or revocation, who completed the home study, etc.)
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Do you operate business from your residence? No Yes - fill in below

TYPE OF BUSINESS
DESCRIBE IMPACT HOME BUSINESS MAY HAVE ON YOUR FOSTER/ADOPTION PLAN

Substitute caregivers

Who do you plan to use as a substitute caregiver for foster children or prospective adoptive children? (E.g., personal care attendant, nurse, babysitter/respice care)

NAME				
AGE		EMAIL ADDRESS		
STREET ADDRESS		CITY	STATE	ZIP CODE
RELATIONSHIP TO CHILD (if any)				

Transportation

Do you have a valid driver's license? Yes No

Do you own vehicles? Yes No

Are there age appropriate car seats? Yes No Will obtain Not applicable

Do you have adequate insurance for all vehicles? Yes No

Do you have access to public transportation? Yes No

DISTANCE TO NEAREST PICK-UP LOCATION

DESCRIBE ALTERNATIVE TRANSPORTATION PLAN IF FAMILY NOT HAVE AN OPERATING VEHICLE OR THE HOME IS NOT NEAR PUBLIC TRANSPORTATION
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Are you able to transport children to appointments or school when needed? Yes No

WHAT ALTERNATIVE TRANSPORTATION ARE YOU ABLE TO PROVIDE?
--

References (required at initial application only)

Reference 1				
LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS			CITY	STATE ZIP CODE
EMAIL ADDRESS				PHONE NUMBER
Reference 2				
LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS			CITY	STATE ZIP CODE
EMAIL ADDRESS				PHONE NUMBER
Reference 3				
LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS			CITY	STATE ZIP CODE
EMAIL ADDRESS				PHONE NUMBER

Municipality (Required at initial licensure only)

Applicants for a non-relative residential program license issued by the Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to inquire about local ordinance requirements. The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Please document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE NUMBER

Child foster care applicants only

Applicant acknowledgment of public funding reimbursement for licensed services:

Department license holders who receive public funding reimbursement for services provided for the care of children in a licensed program must acknowledge that they will comply with funding requirements, that compliance with those requirements may be monitored by the department's Licensing Division, and they know the consequences for not complying with those requirements [Minnesota Statutes, section 245A.04, subd. 1 (h)].

As a child foster care provider, I acknowledge that I will receive public funding reimbursement for the licensed services provided in my program and will comply with all requirements.

Notice about variances

All foster care licensing agencies are required to provide applicants with a summary of the child foster care license requirements and standards. A variance to these requirements and standards may be requested in circumstances that do not jeopardize the health or safety of a child. County and child-placing agencies have the authority to issue most variances. Only the department has authority to grant variances for dual licensure, child foster care maximum age requirements, chemical use problems, and variances regarding individuals disqualified for child foster care licensure based on background study information.

By signing below:

I acknowledge that I have received the Applicant Privacy Notice: Child Foster Care and/or the Notice of Privacy Practices (DHS-3979). I also acknowledge that the information I have provided on this application is complete and true. I agree that:

- The commissioner's representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect my home and its grounds at any time.
- The documentation and inspection required by the rules are necessary for the commissioner to determine whether I am complying with Minnesota Rules and Laws.
- Any documentation that I provide or representations that I make to the commissioner's representative during the time that I am licensed, or throughout the adoption process, or during the license application process will be complete and true and that any misrepresentations or other violations of Minnesota rules and laws may result in immediate suspension, revocation or denial of a child foster care license or denial of an adoption home study.

I understand that failure to provide complete and true information on this application may result in denial of my child foster care application; revocation of my child foster care license; or termination of adoption services.

APPLICANT 1 SIGNATURE	DATE
APPLICANT 2 SIGNATURE	DATE

Authorized agent information

You must designate one controlling individual to act as the authorized agent. The agent is authorized to accept service on behalf of all controlling individuals or individual license holders of the program. Service on the agent is service on all controlling individuals or license holders of the program. It is the responsibility of an authorized agent to ensure mail received from the department is distributed as needed, and a response provided within stated timelines, when required.

Who is the authorized agent for your child foster care program? (required only for new applicants who do not have a license holder entity ID number)

NAME	EMAIL ADDRESS

Applicant Agreement, Acknowledgement and Verification Form

At initial application only: The authorized agent must review and approve the license application by signing below. **The signature must be made in the presence of a notary public.** An original notarized copy of the Applicant Agreement, Acknowledgement and Verification Form is required for each application.

At relicensing: Notarization is not required. The authorized agent must review and approve the license application and must sign and date the application.

By signing below, I agree that the information that I have provided on this application form is true, accurate and complete. If the commissioner of Human Services grants me a license, I agree to comply with the requirements in Minnesota Statutes, chapter 245A and all applicable laws and rules, at all times during the terms of the license. I acknowledge that the commissioner's representative has the right to request any documentation required by Minnesota rules or laws and to inspect the facility/ service at any time during the hours that services are provided. I acknowledge that the documentation and inspection required by statutes and rules are necessary for the commissioner to determine whether I am complying with Minnesota Rules and Laws. I understand that the commissioner may fine, suspend, revoke or make conditional, or deny a license if an applicant or a license holder fails to comply fully with applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license or during an investigation.

Authorized agent:

I, _____ (PRINT FULL LEGAL NAME) state that I am the authorized agent for the license holder identified above. I understand that, by signing below, I am responsible for dealing with the commissioner of Human Services on all matters provided for in Minnesota Statutes, chapter 245A. I also understand that service of all notices and orders affecting any license held by the license holder identified above may be made on me, in accordance with Minnesota Statutes, section 245A.04, subd 1.

State of Minnesota, county of _____
Signed or attested before me on (DATE) _____
_____ SIGNATURE OF NOTARY OFFICIAL

SIGNATURE (sign in front of notary public at initial application)

DATE (for re-licensing only)

Applicant Privacy Notice: Child Foster Care

To apply for a license, you must provide identifying information. Some of this information is public unless there is an identified reason for the information to be not public. You must allow for your program to be inspected by a licensing agency.

What information is public?

- The applicant/license holder name, address and telephone number
- The license number, license status, services provided under the license, and any limitations on the license
- Licensing actions taken regarding your application or license.

How is information made available?

Information regarding licenses can be accessed using our online Licensing Information Lookup search tool on the department's public website. The information can be found at [Licensing Information Lookup](#) or <http://mn.gov/dhs/general-public/licensing/>.

What if I do not want my identifying information made public?

There are circumstances when public identifying information can be limited in order to ensure the safety of children in foster care. If you believe this applies to you, talk with your licensing worker about limiting your public information.

Will information I give be shared with anyone else?

Department staff may give information about you and your program to others authorized under state or federal law. Information will be shared on an as-needed basis to conduct investigations or to provide assistance to you or your program.

What if I refuse or withhold information?

Knowingly withholding relevant information, or giving false or misleading information for your license application, may result in denial of your application, or suspension or revocation of a license that has already been issued.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶክመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮች ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打 1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သ့ၣ်ဟ်သးဘၣ်တၢ်ကၢ်. ဝဲန့ၣ်လိၣ်ဘၣ်တၢ်မၤစၢၤကလီၤလၢတၢ်ကၢ်တၢ်ထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်,သံကွၢ်ဘၣ်ပုၤဂ့ၢ်ဖိအပုၤမၤစၢၤတၢ်လၢန့ၢ်မ့တၢ် မ့ၢ်ကိးဘၣ် 1-844-217-3549 တၢ်ကၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າທ່ານ ທ່ານ ຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພໍດີ, ຈົ່ງຖາມພະນັກງານກຳກັບການຊ່ວຍເຫຼືອຂອງທ່ານ ຫຼື ໂທໂປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.


Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniim. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

1B1 (8-16)



For accessible formats of this publication or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4671, or use your preferred relay service. (ADA1 [9-15])