

**FOSTER HOME RELICENSE APPLICATION
NORTH CAROLINA DIVISION OF SOCIAL SERVICES**

Attach Cover Letter and a copy of DSS-5015 License Action Request form for all requests

Foster Parent(s) Name(s): _____

Facility ID#: _____

1. Background Checks {Must be completed on each foster parent and each adult (18 years old and up)}

Name of Each Adult in the Home:		
Type of Background Check (List all findings, include those on initial 5016 and previous 5157's)	Check Conducted	Date Conducted
Local Court Record Checked by Agency Staff	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Findings & Dates:		
Explanation of Findings:		
NC Department of Public Safety Offender Information	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Findings & Dates:		
Explanation of Findings:		
NC Sex Offender and Public Protection Registry	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Findings & Dates:		
Explanation of Findings:		
Health Care Personnel Registry	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date:
Findings & Dates:		
Explanation of Findings:		

2. North Carolina Child Abuse Neglect History (Foster parents and adult household members)

Child Abuse or Neglect Reported	<input type="checkbox"/> YES <input type="checkbox"/> NO
Substantiation: <input type="checkbox"/> YES, Date of Substantiation: _____	<input type="checkbox"/> NO <input type="checkbox"/> N/A
Explanation of Findings:	

3. Complete if new adult household members have NOT resided in NC for the past five years.

Previous Address(es)	Dates of Residency
Child Central Registry Check(s) from above State(s) of residence regarding applicant as a perpetrator of abuse or neglect if he/she DID NOT reside in NC for the past five years.	Date Conducted: _____
Place child abuse/neglect clearance letters from other state(s) after the signature page. Any findings of child abuse/neglect, criminal history or background check offenses will require a letter of explanation and support from the agency director.	

4. Are any new adults (18 years old and up) residing in the home? YES NO
- a. Are these adults included in the Background checks above? YES NO N/A
- b. Are Fingerprint Clearance letters attached? YES NO N/A
- c. Are RIL results attached? YES NO N/A
- d. Are Child Central Registry Checks from other State(s) attached if the adults did not reside in N.C for the past five years? YES NO N/A
5. Each foster parent received the required 20 hours of in-service training? YES NO
6. Do the foster parents have current training in First Aid, CPR, Universal Precautions and Medication Administration? YES NO
7. Foster parent(s) using physical restraint holds receive required training prior to use of physical restraint holds? YES NO N/A
8. Annual written approval to use physical restraint holds from the Executive Director provided to foster parent(s) and placed in file? YES NO N/A
9. Foster parent(s) using physical restraints only do so when a second trained foster parent or adult is present? YES NO N/A
10. Therapeutic foster parent(s) have received additional training within first two years of licensure as required by 10A NCAC 70E .1117? YES NO N/A
11. Total number of children in the home. **Complete Each Blank.**
- _____ # foster parent(s) minor children including birth, adoptive, guardian
- _____ # relative children who are not in foster care
- _____ # non-relative children (do not count foster children or daycare children)
- _____ # In-Home Daycare License Capacity, attach copy of license
- _____ # Community Alternative Program (CAP) clients in the home
- _____ # foster care license **capacity** as printed on most current DSS-5015
- _____ Total of numbers above
12. Required forms attached?
- DSS-5156 Medical Evaluation YES NO
- DSS-5017 Medical History YES NO
- DSS-1515 Fire Inspection Report YES NO
- DSS-5150 Environmental Conditions Report YES NO

13. Did foster parents, household members, medical provider (DSS-5156 Medical Evaluation) or agency identify any new **Physical Health** issues since the last review? YES NO

If **YES**, answer the following questions.

What is the condition?

What is the duration of the condition?

How does it manifest?

What are the symptoms?

Does the condition affect activities of daily living?

What is the treatment for the condition?

Will the condition affect their ability to provide foster care?

Attach medical provider notes as needed.

14. Did foster parents, household members, medical provider (DSS-5156 Medical Evaluation) or agency identify any new **Mental Health** issues since the last review? YES NO

If **YES**, answer the following questions.

What is the condition?

What is the duration of the condition?

How does it manifest?

What are the symptoms?

Does the condition affect activities of daily living?

What is the treatment for the condition?

Will the condition affect their ability to provide foster care?

Attach medical provider, psychologist, counselor, therapist notes as needed.

15. Have any new pets been added to the household? YES NO

If **YES**, answer the following questions:

How many pets?

What type of pets?

What are the breeds of the pets?

What are the sizes of the pets?

Do the pets live inside or outside of the home?

Have the pets been vaccinated for rabies?

Are all pet vaccinations up-to-date?

How long have the pets been part of the household?

Have the pets been spayed or neutered?

Have the pets displayed any incidents of aggression or violence?

How do the pets react to strangers?

Have the pets been evaluated by a trainer?

Are there any concerns about how the pets will interact with foster children?

Have any pets been removed from the home since the last review? YES NO

If YES, which pets have been removed? _____

16. Has there been a change in the foster parents' employment since the last review? YES NO
If YES, explain:

The licensing social worker has documented the monthly income and monthly expenses of the applicants. YES NO

This documentation is maintained in the supervising agency's file for the applicants. YES NO

The licensing social worker has advised applicants that foster care reimbursement cannot be counted as monthly income. YES NO

Monthly Net Income, Give Total: _____

Monthly Expenses, Give Total: _____

Has the 5015 (Foster Care Facility Action Request) field 26 been updated to reflect the current income? YES NO

17. DSS-1796 Agency/Foster Parent Agreement reviewed and signed; a copy retained in agency foster parent file and a copy given to foster parents? YES NO

18. Discipline Agreement reviewed and signed; a copy retained in agency foster parent file and a copy given to foster parents? YES NO

19. Waiver of licensure rule previously granted? YES NO

20. Waiver of licensure rule being requested? If YES attach DSS-5199 Waiver Request Form YES NO

FOSTER HOME RELICENSE CERTIFICATION

(Foster Parent(s), Social Worker and Agency Director/Designee Signatures Required)

We certify that agency staff has reviewed this document and confirm that the home is in compliance with all rules and policies governing foster home licensure. We understand that according to GS 131D-10.6C this information may be furnished to others upon proper request.

Type Name of Foster Parent	Type Name of Foster Parent
✓	✓
Foster Parent Signature / Date	Foster Parent Signature / Date

Type Name of Foster Parent	Type Name of Foster Parent
✓	✓
Foster Parent Signature / Date	Foster Parent Signature / Date

Type Name of Social Worker	
✓	
Social Worker Signature / Date	
Social Worker Phone Number:	
Social Worker E-Mail Address:	

Type Name of Agency Director or Designee*	
*I certify that the Agency Director has appointed me as Designee for the purpose of signing documents for Regulatory and Licensing Services.	
✓	
Signature of Agency Director or Designee / Date	
Director/Designee Phone Number:	
Director/Designee E-Mail Address:	