

Foster Care & Adoption | Counseling Report

PERSON TO BE ADDRESSED IN THIS REPORT:

Full Name _____

Date of Birth _____

I agree that the findings of this report be shared with Children's Home & LSS, LLC. This consent is valid for one year from the date of signature. I authorize Children's Home to have ongoing written and verbal contact with the provider listed below. I understand and agree that my electronic signature is the legal equivalent of my manual/handwritten signature on this document and is as valid as if I signed the document in writing.

Signature of person addressed in this report**RETURN COMPLETED FORMS TO :**FCAApplications@chlss.org

Fax: 651.646.0436

Date**Please have a provider complete the following report for the above-named adult.**

Dates of service & length of treatment _____

Diagnoses:

Areas of focus for your work together:

Progress and current prognosis:

Impression of emotional maturity and ability to function as foster and/or adoptive parent:

To the best of my knowledge, I have disclosed all compromising information about the above-named person.

PROVIDER | Signature _____

Date_____

Physician Name & License: _____

Clinic Address: _____