DEPARTMENT OF HUMAN SERVICES

DHS-4258A-ENG 1-21

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

◯ New application ◯ Update ◯ Renewal ◯ Change of premises

APPLYING FOR

☐ Foster care/adoption ☐ International or Domestic Infant Adoption

TYPE OF CHILD YOU ARE INTERESTED IN

◯ Male ◯ Female ◯ Either Age range _____

☐ Sibling group of up to _____ children

☐ Specific child _____

FOR INTERNATIONAL ADOPTION ONLY
INDICATE SPECIFIC COUNTRY OR AREA REQUESTED

Applicant 1

Share about yourself and where you live.

LAST NAME	FIRST NAME	MIDDLE NAME	FORMER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS
		◯ Married ◯ Divorced ◯ Separated ◯ Single

RACE

☐ Asian ☐ American Indian/Alaska Native

☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ White

ETHNICITY

Hispanic ◯ Yes ◯ No

CURRENT HOME (STREET) ADDRESS (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 WORK WEEK	TYPICAL WORK SCHEDULE

Have you lived at any other address in the past 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.

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 ◯ Married ◯ Divorced ◯ Separated ◯ Single	
RACE ☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ White			ETHNICITY Hispanic ◯ Yes ◯ No
CURRENT HOME (STREET) ADDRESS (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 past 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 who does not live in your household and would know how to contact you in case of emergency and/or evacuation.

NAME	PHONE

If an emergency evacuation of a home is necessary due to disaster, indicate the specific location where foster children would go (e.g. name of local hotel, address of emergency contact person or foster child's relative):

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 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 ☐ Bus ☐ Other _____

DOES APPLICANT HOME SCHOOL?

◯ No ◯ Yes – has applicant's home school plan been approved by the public school district? ◯ Yes ◯ No

Does anyone smoke in the home? ◯ No ◯ 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? ◯ No ◯ Yes - fill in below

WHAT TYPE(S) OF PETS?

DO ANY PETS IN THE HOME POSE SAFETY CONCERNS?	DO PETS HAVE CURRENT VACCINATIONS?
◯ Yes ◯ No	◯ Yes ◯ No

Dwelling information (check all that apply)

☐ Own ☐ Rent	☐ Mobile home ☐ Basement	☐ Single family house ☐ Multi-unit (apartment)	☐ 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.			

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
4.			

LIST AREAS AND/OR ITEMS IN YOUR HOME THAT ARE LOCKED AND/OR INACCESSIBLE TO 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)

☐ Family child care ☐ Child foster care ☐ Adult foster/community residential setting ☐ Family adult day services
☐ 245D-HCBS ☐ Other

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 the subject of an unfavorable home study?

◯ No ◯ Yes

EXPLAIN (include license type, denial or revocation, who completed the home study, etc.)

Do you operate a business from your residence? ◯ No ◯ Yes

TYPE OF BUSINESS

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

Substitute caregivers

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

NAME

AGE	PHONE AND/OR EMAIL ADDRESS		
STREET ADDRESS	CITY	STATE	ZIP CODE
RELATIONSHIP TO CHILD (if any)			

Transportation

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

Do you own vehicles? ◯ No ◯ Yes

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

Do you have adequate insurance for all vehicles? ◯ No ◯ Yes

Do you have access to public transportation? ◯ No ◯ Yes

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

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

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

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

Municipality (Required at initial licensure only)

Applicants for a non-relative residential program license issued by the Minnesota 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. Document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE

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

☐ ***As a foster care provider of a child, I acknowledge that I will receive public funding reimbursement for 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 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 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 received the Applicant Privacy Notice: Child Foster Care and/or the Notice of Privacy Practices (DHS-3979). I also acknowledge that information I have provided on this application is complete and true. I agree that:

- I will comply with requirements in Minnesota Statutes, chapter 245A, and all applicable laws and rules, at all times during terms of the license.
- The department's commissioner 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 rules are necessary for the commissioner to determine whether I am complying with Minnesota rules and laws.
- Any documentation I provide or representations that I make to the commissioner's representative during the application process, during the time I am licensed, during an investigation or throughout the adoption process, will be complete and true. I understand 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, denial of an adoption home study, or termination of adoption services.

APPLICANT 1 SIGNATURE	DATE
APPLICANT 2 SIGNATURE	DATE

Authorized agent information (Required only for new applicants)

If more than one applicant, you must designate one applicant to act as the authorized agent authorized to accept service on behalf of all individual license holders of the program. Service on the authorized agent is on all license holders of the program. It is the responsibility of authorized agent to distribute mail received from the department within the facility as needed, and a response provided within stated timelines, when required.

Who is the authorized agent for your child foster care program?

NAME	EMAIL ADDRESS

Applicant Privacy Notice: Child foster care

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

What information is public?

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

How license information is made available

Access information about a license by using the online Licensing Information Lookup search tool on the department's website. See 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 to ensure the safety of children in foster care. If you believe this applies to you, talk with your licensing worker about limiting public information.

Will licensing information be shared with anyone?

Department staff may give information about you and your program to others authorized under state or federal law. Information is only shared on an as-needed basis to conduct investigations, or provide needed 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 already issued.

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

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን 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.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ တီလ်ာမီတခါအံၤန္ဉ်,သံကွ်ဘဉ်ပှၤဂ့ၢ်ဝီဒုပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တကွ်.

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

ໂປຣດຊາບ. ຖ້າທ່ານ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 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.

Digniin. 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.

LB1 (8-16)

ADA Advisory

For accessible formats of this information 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 (2-18)

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf