Dear ___________________________,

Thank you for your interest in becoming a foster and/or adoptive parent for children in the care of the Department of Children, Youth and Families. Enclosed please find an application, two (2) Physician’s Reference Forms (one for each applicant) and informational material regarding both foster care and adoption.

Please complete and sign the application form. The physician’s reference form consists of two sheets:

- Authorization to Obtain information form, please fill in all the relevant information (see enclosed instructions).
- Physician’s Reference Form, please write in your name and address (please print clearly).

Return both the application, signed Authorization to Obtain and the Physician’s Reference Form.

If I can answer any further questions or provide any assistance, please call me at: (401) 528-3700. Thank you again for your interest in being a resource parent for our children.

Sincerely,

Robin Perez, MSW
Community Services Coordinator
STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Children, Youth and Families
PERMANENCY SERVICES UNIT
101 Friendship Street 4th Fl.
Providence, RI 02903

FINGERPRINTING

Dear Prospective Foster Care/Adoptive Family Applicant(s),

An amendment to the Rhode Island General Law 15-7-11, relating to criminal checks of prospective foster care/adoptive homes became effective in July 2004. This provision requires all prospective foster care/adoptive parents to undergo a nationwide criminal identification check. Fingerprints of foster care/adoptive parent applicants must be taken by the state police, local police departments or at the DCYF Providence Office. The law requires that the cost for this criminal record check shall be conducted without charge to the actual applicant(s) however for other adult household members they should contact DCYF as the police departments will not conduct the fingerprinting and/or a may charge a fee.

Please call the state police, your local police department or Cindy Stanley at DCYF (401) 528-3470 and ask for an appointment to be fingerprinted for the purpose of approval as foster/adoptive parent. Remember all adult members of the household must be fingerprinted. Please ask that the fingerprinting results be sent directly to: DCYF, Permanency Support Unit, 101 Friendship Street 4th Floor, Providence, RI 02903.

Sincerely Yours,

Robin Perez, MSW
Community Support Coordinator
R.I. DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

STEPS REQUIRED TO OBTAIN A FOSTER CARE / ADOPTION LICENSE

APPLICATION
Foster Care / Adoption Application, Physician’s Reference Forms, and Personal References are received by the Permanency Services Unit.

ATTORNEY GENERAL’S OFFICE CLEARANCE
Names and birth dates of the applicant(s) and adult members of the household are cleared through the Department of the Attorney General, Division of Criminal Identification, to determine if they have been convicted of any crimes involving persons, children, weapons, or illegal substance abuse. Foster / Adoptive parent applicants and all other adult members of the household will also need to be fingerprinted in order for a national criminal clearance to be completed.

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES CLEARANCE
Names and birth dates of all members of the household and their children are cleared through DCYF records to determine if there has been any involvement with the Department through substantiated incidents of child abuse or neglect or Juvenile Corrections. Child Welfare clearances will also be conducted in any other states the applicants have lived in within the previous five years.

TRAINING
Foster and Adoptive Parent Pre-service Orientation Training will be held one evening a week for ten weeks. Each class will last for three hours, for a total of thirty hours of training. You will be oriented to the roles of foster and adoptive parenting, the function of DCYF, and the needs of children in care. You will receive information on registering for foster and adoptive parent training once your application and clearances are received. You must have completed the application and clearance steps before you can register for classes. Both parents must attend training.

FIRE INSPECTION
You will be contacted by a DCYF fire inspector for an inspection to ensure compliance with fire codes. DCYF will assist with the cost of required smoke detectors and remote boiler switch. Maximum reimbursement is $125 for a remote boiler switch and $25 for each smoke detector.

LEAD INSPECTION
If your residence was built prior to 1978, you will be required to provide documentation that your home has passed a lead inspection before you can be licensed.

PHYSICIAN’S REFERENCE
Medical references for each adult member of the household will be obtained from your physicians.

HOME STUDY
A social worker will contact you to schedule a home study once background checks are completed and you are in the foster and adoptive parent training process. The home study will describe your personal history and background and will emphasize the care and support you are able to provide to a child. The home study is the document that will be utilized for matching purposes. The home study process consists of two to four visits.

For more information, please contact Robin Perez, Community Services Coordinator, at (401) 528-3700 or by e-mail at Robin.Perez@dcyf.ri.gov Thank you for your interest our children!
Description of the TIPS-MAPP (Trauma Informed Partnering For Safety and Permanence—Model Approach to Partnerships in Parenting) Foster/Adoptive Parent Program – 30 hours

Week # 1 WELCOME TO THE PS-MAPP PREPARATION AND SELECTION PROGRAM

Acquaints leaders and participants with the TIPS-MAPP Program and each other. This meeting explains the process of becoming a foster or adoptive parent and the legal foundation for child welfare services. With a focus on safety, well-being and permanence, you will meet several children and parents (in a video) who have been involved with foster care and adoption.

Week # 2 WHERE THE MAPP LEADS: A FOSTER CARE AND ADOPTION EXPERIENCE

This meeting provides an overview of a foster care and adoption experience from the perspectives of clients (children and parents), foster parents, adoptive parents, and child welfare workers. Case examples of eight children will be used to help participants consider the safety, well-being and permanence needs of children who have been abused, neglected or maltreated.

Week # 3 LOSSES AND GAINS: THE NEED TO BE A LOSS EXPERT

Explores the impact of separation on the growth and development of children, and the impact of foster care and adoptive placement on the emotions and behaviors of children and parents. Examines personal losses (death, divorce, infertility, children leaving home) and how difficult life experiences affect success as adoptive parents or foster parents. Emphasizes the partnership roles of foster parents, adoptive parents, and social workers in turning separation losses into gains.

Week # 4 HELPING CHILDREN WITH ATTACHMENTS

Explores the subject of attachment and child development. Focuses on how attachments are formed and the special needs of children in foster care and adoption (especially in the areas of building self-concept and appropriate behavior). Discusses the partnership roles of foster parents, adoptive parents and child welfare workers in helping children form new attachments.

Week # 5 HELPING CHILDREN LEARN HEALTHY BEHAVIORS

Discusses techniques for managing behavior, with an emphasis on alternatives to physical punishment. Topics include special issues related to discipline for children who have been physically or sexually abused or neglected. Techniques to be discussed include being a “behavior detective,” reinforcement, time out, mutual problem solving, structuring and setting limits, negotiating, and contracting. Emphasizes the partnership among foster parents, adoptive parents and child welfare workers.

Week # 6 HELPING CHILDREN WITH BIRTH FAMILY CONNECTIONS

Examines the importance of helping children in care maintain and build upon their identity, self-concept, and connections. Considers issues such as how children’s cultures and ethnic backgrounds help shape their identity; the connections children risk losing when they enter care; and why visits and contacts with birth families and previous foster families are important.
Week # 7 GAINS AND LOSSES: HELPING CHILDREN LEAVE FOSTER CARE

Discusses family reunification as the primary case planning goal as well as alternatives like foster care, adoption, and independent living. Examines disruption and its impact on children, families, and agency staff. This meeting also focuses on the partnership role of child welfare workers, foster parents, and adoptive parents in helping children move home, into an adoptive home or into independent living. The meeting features a video of a mother, foster mother and worker planning the return of the mother’s children to her home.

Week # 8 UNDERSTANDING THE IMPACT OF FOSTERING OR ADOPTING

Previous meetings included discussions and experiential activities to find out what foster care and adoption are all about. Participants learned about separation and attachment, how to build and maintain relationships with children and how to support them in working out the emotions they have for the important people in their lives. In Meeting 8 prospective parents explore the impact of fostering and adopting on their own families. Discussions and activities examine how fostering and adopting can affect prospective parents’ marriages own children and relationships with extended family.

Week # 9 PERSPECTIVES IN ADOPTIVE PARENTING AND FOSTER PARENTING

Option # 1 This meeting continues the examination of the impact of foster and adopting on families and builds skills for shared parenting. The meeting features a video of a parent talking about her experiences when her daughters were in foster care. A parent panel of experienced foster and adoptive parents will share their experiences with the group.

Week # 10 ENDINGS AND BEGINNINGS

The important tasks of this meeting will be to assess group members’ strengths and needs as foster parents or adoptive parents. There also will be some time to say good-bye ... the ending. As the preparation/mutual selection process is coming to an end, so begins the transition into becoming a foster family or adoptive family ... the beginning.
DEPARTMENT OF CHILDREN, YOUTH & FAMILIES
ADOPTION & FOSTER CARE APPLICATION

PLEASE PRINT
Please check one of the following:

□ Adoption Only

□ Foster License (Non - relative)  □ Foster Re-license (Non - relative)

□ Foster License - Relative   □ Foster Re-license - Relative

□ Foster License - Non-Relative Child Specific □ Foster Re-license - Non-Relative Child Specific

Name(s) of children for whom you are already providing care or for whom you want to provide care -
(Relative/Child-specific – not biological)

DOB:
DOB:
DOB:
DOB:

What is your relationship to/with child/children? ________________________________

1. Applicant #1:

Last Name    First    Middle    Maiden    DOB

Social Security No.    Race    Hispanic – Y/N    Religious Affiliation

2. Applicant #2:

Last Name    First    Middle    Maiden    DOB

Social Security No.    Race    Hispanic – Y/N    Religious Affiliation

3. Address:

Number and Street    City or Town    Zip Code

Email address: ________________________________

DCYF #036
(Use with Policies: 900.0020 & 900.0025

Version 2/8/05
4. Telephone Number(s):

Applicant #1:
Home: ___________________ Work: ___________________
Cell #1: ___________________ Cell #2: ___________________

Applicant #2:

May we call you at work?  Applicant #1: □ Yes □ No  Applicant #2: □ Yes □ No

5. Directions to your home (from Providence):
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

6. Please indicate city/town, state and dates of residency (for the past 5 years).

Applicant #1:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Applicant #2:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

7. Date and Place of Marriage/ Commitment Ceremony:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

8. Date(s) and Place(s) of any previous marriages, committed partnerships and divorces
(Please include all previous married names):

Applicant #1:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Applicant #2:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
9. Please provide the following information about ALL your child(ren) including birth, step, and adoptive, regardless of age or current residence:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>DOB</th>
<th>Sex</th>
<th>Living with you? Y/N</th>
<th>Adopted? Y/N</th>
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10. Please list all other members of your household:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>DOB</th>
<th>Relationship to you</th>
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11. What languages are spoken in your home?

Do you need an interpreter? □ Yes □ No
Are you able to read and understand English? □ Yes □ No

12. Do you require any physical accommodation and/or assistance to help you participate in the DCYF training process? □ Yes □ No
If so, what accommodation/assistance would you need?

13. Please provide the following information regarding your employment for the past 3 years.

**Applicant #1:**

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Address:</th>
<th>Start/End Date:</th>
<th>Position:</th>
<th>Work days/Hours</th>
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**Applicant #2:**

<table>
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<th>Employer:</th>
<th>Address:</th>
<th>Start/End Date:</th>
<th>Position:</th>
<th>Work days/Hours</th>
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14. Do you have any other source of income? □ Yes □ No If yes, please explain:

15. Have you, your partner, your child(ren), or any member of your household ever been the subject of an investigation by Child Protective Services in RI or any other state? □ Yes □ No If yes, please explain:

16. Have you or your partner ever had a child or children placed outside of your home by this or any other state? □ Yes □ No If yes, please explain:

17. Have you, your partner, your children, or any member of your household ever received services from DCYF, the Rhode Island Training School or Juvenile Probation? □ Yes □ No If yes please explain:

18. Have you or your partner ever been licensed for day care, foster care or adoption or have you ever applied to do so? □ Yes □ No If yes please explain:
19. Have you, your partner, your child(ren), or any member of your household ever received counseling from or had any previous involvement with a Human Service Agency, Mental Health Clinic/Facility, a private therapist, Family Service Agency, Counseling Center, Adoption Agency, etc.? □ Yes □ No
   If yes, please note the agency, dates and reason for involvement:

20. Have you, your partner, your child(ren), or any member of your household ever been arrested, or charged by the police or been arraigned, indicted, or convicted of any offense in any state? □ Yes □ No
   If yes, please explain:

21. Do you or your partner have any chronic illness or handicap that may affect your capacity to parent a child, who may be physically, emotionally or behaviorally challenging? □ Yes □ No
   If yes, please explain:

22. Do you or any member of your household have a history of mental illness that may affect your capacity to parent a child who may be physically, emotionally or behaviorally challenging? □ Yes □ No
   If yes, please explain:

23. Please list below all physicians with whom members of your family are involved:

<table>
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<tr>
<th>Physician</th>
<th>Address</th>
<th>Family Member</th>
<th>Reason</th>
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DCYF #036
(Use with Policies: 900.0020 & 900.0025)
24. Personal References:

Please list four (4) persons who have known you for at least two years and can comment on your family’s lifestyle and values. Please inform them that they will be used as references and will be receiving a letter from the Department, requesting a personal reference response. Also, please ask them to return their response to the Department as soon as possible, as this will help us expedite processing your application.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Complete Address and Zip Code</th>
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<tr>
<td>(Non-Relative) 1.</td>
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<tr>
<td>(Non-Relative) 2.</td>
<td></td>
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<tr>
<td>(Relative) 3.</td>
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<td>(Either) 4.</td>
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Please identify all adult children that you have parented (birth, step, adoptive, or other). The Department will be seeking references from all adult children of Adoptive applicants.

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<th>Full Name</th>
<th>Address</th>
<th>Telephone</th>
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(For additional children, please utilize reverse side of document.)

25. Housing & Safety Factors

Do you own your own home? □ Yes □ No

In what type of housing do you live? □ Single family □ Multi - family □ Section 8
□ Public housing □ Subsidized housing

How many rooms are in your home? __________ How many bedrooms? __________

Was your residence built after 1978? □ Yes □ No

Is your home lead safe? □ Yes □ No □ Unsure

Do you own a gun? □ Yes □ No

If Yes, where and how is it stored, as to be inaccessible to children?
Is there a swimming pool on the property? □ Yes □ No
If yes, is it securely fenced? □ Yes □ No

Please list your pets:
□ None

<table>
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<tr>
<th>Type of Pet</th>
<th>Licensed? (Yes/No)</th>
<th>Up to date on Rabies Inoculations? (Yes/No)</th>
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How do your pets relate with children?

26. Matching Factors - To be completed by Adoption Applicants and Foster Care Non-Relative Applicants.

(Relative and Child-specific Foster Care Applicants do not need to complete this section.)

What is your preference regarding the child/children for whom you would like to be considered as a foster or adoptive resource?

Age Range: From _______ To _______ Gender: □ Male □ Female □ No Preference

Sibling Group: □ Yes □ No □ Undecided

Would your family consider fostering or adopting a child from a racial, cultural or ethnic group other than your own? □ Yes □ No □ Undecided

Please check the degree of handicapping conditions you feel you might consider.

Physical: □ None □ Mild □ Moderate □ Severe

Emotional: □ None □ Mild □ Moderate □ Severe

DCYF #036 (Use with Policies: 900.0020 & 900.0025) Version 2/8/05
Intellectual:  □ None  □ Mild  □ Moderate  □ Severe
Please Read Carefully

I/We, the undersigned, attest that the information contained in this application is complete and accurate. I/We understand that any false representation on this application may be cause for denial of the license, which is sought or immediate revocation of any license if it has been issued. I/We further understand that all members of my/our household will be cleared through the record of the Division of Criminal Identification and/or local law enforcement authorities and the records of the Department of Children, Youth and Families.

Applicant #1

Date

Applicant #2

Date

Foster Care Applicants Return Application To:

The Department of Children, Youth, & Families
101 Friendship Street, 3rd Floor
Providence, RI 02903
Attn: Robin Perez

Adoption Applicants Return Application To:

The Department of Children, Youth, & Families
Adoption & Foster Care Preparation & Support Unit
101 Friendship Street, 3rd Floor
Providence, RI 02903

DCYF #036
(Use with Policies: 900.0020 & 900.0025)
Motivation to Foster or Adopt

A Worksheet to be done individually by each applicant
Use back of paper if necessary.

Name: ______________________________________

1. How long did you think about fostering or adopting before applying and who spoke of it first?

2. How did you hear of this program?

3. Why do you want to foster or adopt a child through this Department?

4. What experience have you had directly or indirectly with foster care or adoption?

5. Many families experience difficulties in conceiving or maintaining a pregnancy. Is this something that you have experienced? □ Yes □ No

If yes, have you taken any steps to alleviate these difficulties? □ Yes □ No

Are any of these issues a major factor in your decision to Foster or Adopt?
□ Yes □ No

6. (If applicable) What understanding do your present children have about foster care or adoption?

7. Many people have experienced trauma in their own lives, such as childhood abuse, sexual abuse, and domestic violence. Have you ever experienced or witnessed any of these?
□ Yes □ No

If yes, briefly explain:

If you are in a relationship, is your partner aware of this? □ Yes □ No

8. What do you see as the strengths you bring to the parenting experience?

9. In what areas might you need help in parenting a child placed with you?

10. Describe any experiences you may have had with child care.
Motivation to Foster or Adopt

A Worksheet to be done individually by each applicant

Use back of paper if necessary.

Name: __________________________________________

1. How long did you think about fostering or adopting before applying and who spoke of it first?

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   If yes, briefly explain:

   If you are in a relationship, is your partner aware of this? □ Yes □ No

8. What do you see as the strengths you bring to the parenting experience?

9. In what areas might you need help in parenting a child placed with you?

10. Describe any experiences you may have had with child care.
INSTRUCTIONS FOR COMPLETING

THE AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION RELEASE

This form (Authorization to Obtain Confidential Information) gives the Department of Children, Youth & Families your permission to send the attached Physician’s Reference for Foster/Adoptive Parent form to your physician to obtain the requested information. One set of forms is required for each foster/adoptive parent applicant.

Client's Name, Address, DOB and Social Security #

Please enter your name, address, DOB and Social Security number

OBTAINT FROM: Name and Address

Please enter your physician’s full name and address in this section.

Start Date

Please enter the approximate begin date of your treatment with the physician

End Date

Please enter either the date of one year from which you sign the release or the date in which you ended the service if you are not currently attending/receiving treatment from this physician

Signature of Client/Legal Guardian or Parent

Please sign your name

Relationship to Client

Please write in ‘Self’

Date Signed

Please write in the date you signed the form

Witness Signature

Please have someone witness your signature

Date Signed

Please have witness date his/her signature

Once the release is fully completed, please return to: Robin Perez, Community Services Coordinator Department of Children, Youth & Families 101 Friendship St. 4th Fl. c/o Permanency Services Unit Providence, RI 02903 Tel (401) 528-3700; Fax (401) 528-3650. Upon receipt of the completed release it will be mailed to your Physician accompanying the Physician’s Reference Form (see attached). If you have any questions, please contact Robin Perez.
STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

Client’s Name: ___________________________ DOB: ___________________________
Client’s Address: ____________________________________________________________

I authorize The Rhode Island Department of Children, Youth and Families to:

OBTAIN FROM: Name: ___________________________
Address: ____________________________________________________________

The following information contained in records pertaining to services provided on or about
(Start Date) ___________________________ (End Date) ___________________________

Please check the appropriate information to be released:
☐ discharge summary    ☐ financial    ☑ substance abuse treatment
☐ psychiatric evaluation ☐ housing    ☐ laboratory data
☐ assessment/progress notes ☐ educational    ☐ HIV/AIDS data
☐ treatment/case plan ☐ psychological tests    ☐ other (be specific)
☐ medical    ☐ Physician’s Reference Form for
☐ other (be specific) Foster/Adoptive Parents

Information can be released via: (check all that apply)
☐ fax    ☑ written materials    ☐ electronic mail    ☐ telephone    ☐ direct contact    ☐ other (be specific)

This information is needed for the following purpose(s):
☐ Case assessment/investigation    ☐ Ongoing services    ☑ Other (be specific) Foster/Adoption Licensing

I understand that my records are processed under RI General Law and cannot be disclosed without my
written consent except as otherwise specifically provided by law. I also understand that if my records involve
alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under Federal Regulation 42 CFR Part
2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23.

I release the Rhode Island Department of Children, Youth and Families (DCYF) and its employees from
any liability arising from the release of this information to such persons/agencies, provided that said release of
information is done substantially in accordance with applicable law.

This consent will have a duration of no longer than one (1) year from the date of this form. I understand
that I may withdraw my consent (in writing to DCYF ) at any time except to the extent that action has been taken in reliance on it.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign the
authorization. I need not sign this form in order to receive services from DCYF. I understand that I may inspect or
obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of
information carries with it a potential for an unauthorized redisclosure and the information may not be protected by
confidentiality rules.

I have read and understand the above statements and do herein voluntarily consent to disclosure of
the above information (including HIV test results and alcohol and drug abuse records if checked above) to
those persons/agencies named above.

Signature of Client/Legal Guardian or Parent                   Relationship to Client                   Date Signed

Witness Signature                                           Date Signed

DCYF #007B
(Use with Policy: 100.0005)
Physician's Reference for Foster/Adoptive Parents

Date: ____________________

An application to be a foster/adoptive parent has been received from: ____________________

Name: ____________________

Address: ____________________

As this is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of the applicant.

In order that we may expedite the processing of the application, we ask that you complete this form at your earliest convenience and return it to:

Robin Perez, Community Services Coordinator
Department of Children, Youth & Families
161 Friendship St. 4th Floor c/o Permanency Services Unit
Providence, RI 02903
Phone (401) 528-3700; fax (401) 528-3650

* Please Note: Complete only this form. Do not send copies of charts or records. *

What is your impression of the applicant's general health? ____________________

Does the applicant have any chronic disease or illness? [ ] Yes [ ] No

If Yes, please explain: ____________________

Do you consider the applicant physically, mentally, and emotionally competent to be a foster/adoptive parent? [ ] Yes [ ] No

If No, please explain: ____________________

Any additional comments? ____________________

Physician's Name and Address (Please Print)

Physician's Signature: ____________________ Date: ____________

NOTE: THE DCYF #007B, AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION SHALL BE FORWARDED TO THE PHYSICIAN ALONG WITH THIS FORM.

DCYF #037
(Use with Policy 900.0020) Version Date 5/03
INSTRUCTIONS FOR COMPLETING

THE AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION RELEASE

This form (Authorization to Obtain Confidential Information) gives the Department of Children, Youth & Families your permission to send the attached Physician’s Reference for Foster/Adoptive Parent form to your physician to obtain the requested information. One set of forms is required for each foster/adoptive parent applicant.

<table>
<thead>
<tr>
<th>Client’s Name, Address, DOB and Social Security #</th>
<th>Please enter your name, address, DOB and Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBTAIN FROM: Name and Address</td>
<td>Please enter your physician’s full name and address in this section</td>
</tr>
<tr>
<td>Start Date</td>
<td>Please enter the approximate begin date of your treatment with the physician</td>
</tr>
<tr>
<td>End Date</td>
<td>Please enter either the date of one year from which you sign the release or the date in which you ended the service if you are not currently attending/receiving treatment from this physician</td>
</tr>
</tbody>
</table>

Signature of Client/Legal Guardian or Parent: Please sign your name

Relationship to Client: Please write in ‘Self’

Date Signed: Please write in the date you signed the form

Witness Signature: Please have someone witness your signature

Date Signed: Please have witness date his/her signature

Once the release is fully completed, please return to: Robin Perez, Community Services Coordinator, Department of Children, Youth & Families 101 Friendship St, 4th FL c/o Permanency Services Unit, Providence, RI 02903 Tel (401) 528-3700; Fax (401) 528-3650. Upon receipt of the completed release it will be mailed to your Physician accompanying the Physician’s Reference Form (see attached). If you have any questions, please contact Robin Perez.
STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

Client’s Name: ___________________________ DOB: ___________________________
Client’s Address: ___________________________________________________________

I authorize The Rhode Island Department of Children, Youth and Families to:

OBTAIN FROM: Name: ______________________________________________________
Address: _________________________________________________________________

The following information contained in records pertaining to services provided on or about
(Start Date) ____________________________ (End Date) ____________________________

Please check the appropriate information to be released:
☒ discharge summary ☐ financial ☑ substance abuse treatment
☒ psychiatric evaluation ☐ housing ☐ laboratory data
☒ assessment/progress notes ☐ educational ☑ HIV/AIDS data
☒ treatment/case plan ☑ psychological tests ☐ Physician’s Reference Form for
☒ medical ☐ other (be specific) ☐ Foster/Adoptive Parents

Information can be released via: (check all that apply)
☒ fax ☒ written materials ☐ electronic mail ☒ telephone ☐ direct contact ☐ other (be specific)

This information is needed for the following purpose (s):
☐ Case assessment/investigation ☐ Ongoing services ☑ Other (be specific) Foster/Adoptive
Licensing

I understand that my records are processed under RI General Law and cannot be disclosed without my
written consent except as otherwise specifically provided by law. I also understand that if my records involve
alcohol or drug abuse, or HIV (AIDS) testing, they are further processed under Federal Regulation 42 CFR Part
2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, Section 23.

I release the Rhode Island Department of Children, Youth and Families (DCYF) and its employees from
any liability arising from the release of this information to such persons/agencies, provided that said release of
information is done substantially in accordance with applicable law.

This consent will have a duration of no longer than one (1) year from the date of this form. I understand
that I may withdraw my consent (in writing to DCYF___________) at any time
except to the extent that action has been taken in reliance on it.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign the
authorization. I need not sign this form in order to receive services from DCYF. I understand that I may inspect or
obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of
information carries with it a potential for an unauthorized redisclosure and the information may not be protected by
confidentiality rules.

I have read and understand the above statements and do herein voluntarily consent to disclosure of
the above information (including HIV test results and alcohol and drug abuse records if checked above) to
those persons/agencies named above.

Signature of Client/Legal Guardian or Parent Relationship to Client Date Signed

Witness Signature Date Signed

DCYF #007B
(Use with Policy: 100.0005)

Version Date 4/03
STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

PHYSICIAN'S REFERENCE FOR FOSTER/ADOPTIVE PARENTS

Date: ____________________

An application to be a foster/adoptive parent has been received from: ____________________ Name

______________________________
Address

As this is frequently a physically and emotionally demanding job, the Department of Children, Youth and Families is interested in the health of the applicant.

In order that we may expedite the processing of the application, we ask that you complete this form at your earliest convenience and return it to: Robin Perez, Community Services Coordinator
Department of Children, Youth & Families
101 Friendship St. 4th Floor c/o Permanency Services Unit
Providence, RI 02903
phone (401) 528-3700; fax (401) 528-3650

* Please Note: Complete only this form. Do not send copies of charts or records. *

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Does the applicant have any chronic disease or illness? [ ] Yes [ ] No

If Yes, please explain:


Do you consider the applicant physically, mentally, and emotionally competent to be a foster/adoptive parent? [ ] Yes [ ] No

If No, please explain:


Any additional comments?


Physician’s Name and Address (Please Print)

______________________________
Physician’s Signature

______________________________
Date

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