FAMILY FOSTER HOME ANNUAL LICENSING REPORT

ND DEPARTMENT OF HUMAN SERVICES
FOSTER CARE
SFN 1941 (Rev. 2-2012)

Clear Fields

INSTRUCTIONS: Complete form with relevant information since date of last licensure study to the present. This information is part of a licensing file - please do not include names of children in foster care. Family must complete "Step One/License Application to Provide Family Foster Care", SFN 893, annually. Send completed SFN 893, completed Annual Licensing Report, and other required documentation to regional supervisor.

Agency:				
Foster Parent's Name:				
Address:		City:	State:	ZIP Code:
Telephone Number: (Home)	Telephone Number: (Work)	Cell Phone Number	Cell Phone Number	

1. Describe **children (no names) in foster care** with this family during past year (age, type of child, behavioral problems, medical needs, etc.)

2. Describe and illustrate the demonstrated ability foster parents have to work as part of the **"team".**

3. Describe significant **skills** foster parents have demonstrated in working with the foster children in their home. (Do they work well with certain child personalities? Have they demonstrated specific skills in working with certain behaviors?)

4. Describe **problems** which have interfered with foster parents providing care for foster children or the functioning of their own family. Are certain behaviors difficult for them to handle, or not handled appropriately?

5. Describe the demonstrated ability of the foster parents in **working with the child's natural parents.**

6. Have foster parents completed necessary training hours? ☐ Yes ☐ No ☐ N/A	Is training verification from CFS-TC attached? ☐ Yes ☐ No

If "No", describe training. (Verification must be in county file.)

If necessary training hours have not been completed, how and when will this be accomplished?

7. Describe any significant changes in the **physical environment** of the home.

8. Describe **effects** of foster care on foster parents and their family:
   a. Positive effects provision of foster care has had on foster parents and family:

   b. Negative effects provision of foster care has had on foster parents and family:

9. **Other** significant information:
   a. Reports of suspected child abuse/neglect? ☐ Yes ☐ No
   If yes, provide date, outcomes, recommendations, negative indicators or circumstances surrounding report.

   b. Licensure violations? ☐ Yes ☐ No If yes, briefly describe violation and action taken.

   c. Other:

10. AGENCY RECOMMENDATION

A. RECOMMENDATION TO LICENSE

I have compiled the information in this study and have toured the home of the applicants. I believe this information to be accurate. Applicants/home meet or exceed the minimal requirements for licensure as a family foster home for children (NDAC 75-03-14). I recommend licensure for 24 hour foster care for children for:

Number of Children:	
☐ Male ☐ Female	Ages: From To

OR

Licensure Specifically for: (Name of Child Only)	
Age:	For the Period: From To
Social Worker/s/:	Date:
Agency:	

Complete study and submit to the Regional Supervisor, with the following attachments:

☐ Application Form SFN 893
☐ Medical reports/self certification
☐ Fire Inspection Report, SFN 800
☐ References
☐ C/AN check has been completed
☐ Lab reports
   ☐ Water (Private well)
   ☐ Milk
☐ Other _____
☐ Other _____

B. RECOMMENDATION TO DENY LICENSE

I have compiled the information in this study and have toured the home of the applicants. I believe this information to be accurate. Applicants/home do not meet the minimal requirements for licensure as a family foster home for children (NDAC 75-03-14).

I recommend that this application be denied based on: (Attach supplemental documentation as necessary)	
Date:	Social Worker/s/:
Agency:	

Complete study and submit to the Regional Supervisor, with the following attachments:

- ☐ Application Form SFN 893
- ☐ Medical reports/self certification
- ☐ Fire inspection report
- ☐ References
- ☐ C/AN check has been completed
- ☐ Lab reports
  - ☐ Water (Private well)
  - ☐ Milk
- ☐ Other _____

11. REGIONAL OFFICE USE ONLY

A. RECEIPT AND REVIEW OF STUDY

Date Study Received:
Study Review Completed:
Missing/Incomplete Information:
Child Abuse/Neglect Register Check:
Contact with Agency for Further Information

B. LICENSE APPROVAL/DENIAL

Number of Child Licensed For:	☐ Male ☐ Female	Ages: From To	Expiration Date:
(Or) License Only For (Name of Child):			Age:
For The Period: From To			
Application Denied Based On:			
(Denial Process Must be Implemented.)			
Regional Supervisor:			
Region:			Date:

DISTRIBUTION: **ORIGINAL** - County Social Service Board **COPY** - Human Service Center