



ANNUAL APPLICATION TO PROVIDE FAMILY FOSTER CARE
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
 FOSTER CARE DIVISION
 SFN 400 (8-2016)

Instructions: Every twelve months a ND foster care license or approval (Tribal Affidavit) must be re-evaluated. A licensed or approved (Tribal Affidavit) foster family must complete this form as part of the annual renewal to provide foster care for children. This information is used to update the payment system, gain a better understanding of the family composition and assist the licensing authorized agent with the annual renewal process.

APPLICANT #1

Full Name			Social Security Number *
Home Telephone Number	Cell Phone Number	Work Telephone Number	Religion
Email Address			
Race/Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Other (specify): <input type="checkbox"/> Native American <input type="checkbox"/> Asian _____			Hispanic Ethnicity <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Re-Married <input type="checkbox"/> Partner/Live-In			

APPLICANT #2

Full Name			Social Security Number *
Home Telephone Number	Cell Phone Number	Work Telephone Number	Religion
Email Address			
Race/Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Other (specify): <input type="checkbox"/> Native American <input type="checkbox"/> Asian _____			Hispanic Ethnicity <input type="checkbox"/> Yes <input type="checkbox"/> No
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Re-Married <input type="checkbox"/> Partner/Live-In			

Applicant Address

Physical Address	City	State	ZIP Code
Mailing Address	City	State	ZIP Code

* The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Persons living in the household other than foster children (Applicant information must be included below)

Household Members	Full Name	Relationship to Applicant	Gender	Birthdate	Occupation/Employment
Applicant #1					
Applicant #2					
Other Adults living in the home <i>List all over the age of 18 years old.</i>					
Children living in the home <i>Do not include foster children on this list.</i>					

In the past 12 months:

Has the applicant been arrested, charged, or convicted of any criminal activity? If yes, explain in detail:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant provided child care (except to own children) in any capacity, either licensed or unlicensed? <i>If yes: Explain in detail:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the applicant received notice of correction, revocation, or denial of a license to provide care to a child? <i>If yes: Explain in detail</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Certification

We/I hereby submit our/my renewal to provide foster care for children in ND. We/I state that we/I:

- a. Have a copy of the NDAC 75-03-14, have read the rules for family foster care homes in ND, and will comply with these rules to provide foster care for children in ND.
- b. Certify that the above information is true to the best of our/my knowledge and we/I grant permission for this information to be verified with the appropriate person or licensing agencies. *(A license or approval to provide foster care to children may be revoked (NDCC 50-11) if issued upon fraudulent or untrue representation.)*

Applicant #1 Signature	Date
Applicant #2 Signature	Date

Licensed Authorized Agent:

Provider License/Approval Information

Current Provider License Number	Number of Licensed Beds	Age Preference	Gender Preference <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both
Current Provider Effective Dates From: _____ To: _____		Renewal License Effective Dates From: _____ To: _____	
Is the provider willing to accept short term shelter care/emergency placements? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Contact Information

Name of Licensing Authorized Agent/Agency	Name of Agency Worker		
Email Address		Telephone Number	
Protective Service Reports? (SFN 960) <input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Home Study Date	Any negative indicators? <input type="checkbox"/> Yes <input type="checkbox"/> No	Assessment Conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Annual C/AN Index Checks completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial Criminal Background Check completed and on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Recommendation to re-license/re-approve? <input type="checkbox"/> Yes <input type="checkbox"/> No-attach a report	
Comments			
Signature of Authorized Agent Worker			Date

NDDHS Only

Date NDDHS Received Paperwork	
Date NDDHS Reviewed Paperwork	
Date Notice of License/Approval (Tribal Affidavit) Sent to the Authorized Licensing Agent	
Comments	
Signature of NDDHS Representative	Date