House of Shiloh Family Services
Child Placement & Adoption Agency

Foster/Adopt Parent Application

Family Name:	**Date:**

How did you hear about House of Shiloh?
☐ Agency Website ☐ Another Agency ☐ Another Foster Parent ☐ DFPS/OC-OK ☐ Church ☐ Google ☐ Other:

Program(s) of Interest:
☐ Foster ☐ Adopt ☐ Foster-to-Adopt ☐ Respite

Current Address City State Zip Code County

☐ Own Home ☐ Rent Home ☐ Apartment ☐ Condo Year Built:______# of Bedrooms:__________# of Bathrooms:_____

Please attach a floor plan of your home indicating the purpose and dimensions of each room.

Marital Status

☐ Married ☐ Divorced ☐ Separated ☐ Single (Never Married) ☐ Co-Habitation ☐ Dating

Any children living in the home?	Any children living outside the home?	Any other household members?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If you are married or cohabitating, both of you must apply below.

Applicant #1	**Applicant #2**
First Middle Last	First Middle Last
Date of Birth: / Place of Birth:	Date of Birth: / Place of Birth:
Gender : ☐ Female ☐ Male	Gender : ☐ Female ☐ Male
Race/Ethnicity:	Race/Ethnicity:
Height: / Weight:	Height: / Weight:
Hair Color: / Eye Color:	Hair Color: / Eye Color:
Language(s):	Language(s):
Social Security Number:	Social Security Number:
U.S. Citizen: ☐ Yes ☐ No Legal Resident: ☐ Yes ☐ No	U.S. Citizen: ☐ Yes ☐ No Legal Resident: ☐ Yes ☐ No
Driver's License #: / State: / Expiration Date:	Driver's License #: / State: / Expiration Date:
Cell Phone Number:	Cell Phone Number:
Email Address:	Email Address:
Religion:	Religion:
Highest Level of Education:	Highest Level of Education:

Current Employment

Employer Name:	Employer Name:
Address City State Zip Code	Address City State Zip Code
Work Phone Number:	Work Phone Number:
Job Title:	Job Title:
Date of Hire:	Date of Hire:
Salary/Wage:	Salary/Wage:
Work Schedule:	Work Schedule:
Supervisor's Name:	Supervisor's Name:
Permission to Contact? ☐ Yes ☐ No	**Permission to Contact?** ☐ Yes ☐ No

If employed by present employment less than 3 years, please list previous employment below.

Employer Name:	Employer Name:
Address City State Zip Code	Address City State Zip Code
Work Phone Number:	Work Phone Number:

Job Title:	Job Title:
Date of Hire: End Date:	Date of Hire: End Date:
Salary/Wage:	Salary/Wage:
Supervisor's Name:	Supervisor's Name:
Permission to Contact? ☐ Yes ☐ No	**Permission to Contact?** ☐ Yes ☐ No

Military Information

Branch(es) of Service:	Branch(es) of Service:
Start Date: End Date:	Start Date: End Date:
Discharged? ☐ Yes ☐ No	Discharged? ☐ Yes ☐ No
Reserves? ☐ Yes ☐ No	Reserves? ☐ Yes ☐ No
Type of Discharge:	Type of Discharge:

Financial Information

Income Source:	Amount: $
Income Source:	Amount: $
Income Source:	Amount: $
Income Source:	Amount: $
Total Monthly Income: $	
Rent/Mortgage	Amount: $
Home/Rental Insurance	Amount: $
Payments for Other Real Estate Property	Amount: $
Car Payment	Amount: $
Car Insurance	Amount: $
Car Maintenance/Fuel	Amount: $
Utilities (Water/Gas/Electric)	Amount: $
Telephone/Internet/Cable	Amount: $
Medical/Dental Care	Amount: $
Childcare	Amount: $
Legal (Child Support, Alimony, Attorney Fees, etc.)	Amount: $
Groceries/Household Supplies	Amount: $
Clothing	Amount: $
Entertainment/Recreation	Amount: $
Credit Cards	Amount: $
Other Debt/Expenses	Amount: $
Total Monthly Expenses: $	

Marital History - **Please submit Divorce Decree/Death Certificate**

Applicant #1		**Applicant #2**	
Previous Spouse: First Middle Last		Previous Spouse: First Middle Last	
From:	To:	From:	To:
Reason for Termination: ☐ Divorce ☐ Death		Reason for Termination: ☐ Divorce ☐ Death	
Children in Marriage? ☐ Yes ☐ No		Children in Marriage? ☐ Yes ☐ No	
Previous Spouse: First Middle Last		Previous Spouse: First Middle Last	
From:	To:	From:	To:
Reason for Termination: ☐ Divorce ☐ Death		Reason for Termination: ☐ Divorce ☐ Death	
Children in Marriage? ☐ Yes ☐ No		Children in Marriage? ☐ Yes ☐ No	

Please use an additional page if more spaces are needed.

Residential History

Please list all places of residence during the previous 10 years.

Address / City / State / Zip Code		Address / City / State / Zip Code	
Address City State Zip Code		Address City State Zip Code	
From:	To:	From:	To:
Address City State Zip Code		Address City State Zip Code	
From:	To:	From:	To:
Address City State Zip Code		Address City State Zip Code	
From:	To:	From:	To:
Address City State Zip Code		Address City State Zip Code	
From:	To:	From:	To:
Address City State Zip Code		Address City State Zip Code	
From:	To:	From:	To:

Please use an additional page if more spaces are needed.

Home & Community Environment

Please attach a copy of Homeowner/Renter's Insurance, Fire Inspection, & Health Inspection

Check any amenities you may have at your home:
☐ Pool ☐ Hot Tub ☐ Pond ☐ Trampoline ☐ Second Story ☐ Fenced Yard ☐ Basement ☐ Garage ☐ Backyard Sheds
☐ Play Equipment ☐ Community Pool ☐ Community Playground

Briefly describe the neighborhood:

Nearest Hospital:	Local Elementary School:
Local Middle School:	Local High School:
Alcoholic Beverages in Home? ☐ Yes ☐ No	If Yes, are they stored in an unlocked refrigerator or out in the open? ☐ Yes ☐ No
Tobacco Products? ☐ Yes ☐ No	Who in the home uses?
Pets? ☐ Yes ☐ No	If Yes, List:
Weapons/Firearms/Projectiles? ☐ Yes ☐ No	If Yes, List and describe how stored:

Do you expect any change in marital status, employment, family size, or place of residence within the next year? ☐ Yes ☐ No

Please attach vaccinations, dated within a year prior to the date of application, for each pet.
Attach copies of Concealed/Open Carry Licenses for any individuals owning a firearm.

Vehicles

Please attach a copy of the following for all drivers: Driver's License and Proof of Insurance.

Vehicle #1	**Vehicle #2**
Make: Model: Year:	Make: Model: Year:

Criminal History

Applicant #1	**Applicant #2**
Have you ever been involved in, either as an aggressor or victim, an act of assault, child battering, child abuse, child molestation, or child neglect? ☐ Yes ☐ No	Have you ever been involved in, either as an aggressor or victim, an act of assault, child battering, child abuse, child molestation, or child neglect? ☐ Yes ☐ No
Have you ever been convicted or are you currently charged with a felony or misdemeanor classified as an offense against a person,	Have you ever been convicted or are you currently charged with a felony or misdemeanor classified as an offense against a person,

family, public indecency, or any violation of the Controlled Substance Act? ☐ Yes ☐ No	family, public indecency, or any violation of the Controlled Substance Act? ☐ Yes ☐ No
Have you ever been charged with a felony? ☐ Yes ☐ No	Have you ever been charged with a felony? ☐ Yes ☐ No
Medical History	
Are you now receiving, or have you ever received treatment for chemical dependency? ☐ Yes ☐ No	Are you now receiving, or have you ever received treatment for chemical dependency? ☐ Yes ☐ No
Have you ever been hospitalized for an emotional or mental illness? ☐ Yes ☐ No	Have you ever been hospitalized for an emotional or mental illness? ☐ Yes ☐ No
Are you now receiving, or have you ever received psychiatric treatment? ☐ Yes ☐ No	Are you now receiving, or have you ever received psychiatric treatment? ☐ Yes ☐ No
Have any of your children ever been placed in foster care, a treatment facility for emotional or mental disturbance, or committed to a state correctional facility? ☐ Yes ☐ No	Have any of your children ever been placed in foster care, a treatment facility for emotional or mental disturbance, or committed to a state correctional facility? ☐ Yes ☐ No
Do you have any significant acute or chronic medical condition that could affect your ability to foster children? ☐ Yes ☐ No	Do you have any significant acute or chronic medical condition that could affect your ability to foster children? ☐ Yes ☐ No
If yes to any of the above, please explain:	If yes to any of the above, please explain:
Describe your current health: ☐ Good ☐ Fair ☐ Poor ☐ Disabled	Describe your current health: ☐ Good ☐ Fair ☐ Poor ☐ Disabled
List any handicaps, serious illnesses, operations, or chronic conditions:	List any handicaps, serious illnesses, operations, or chronic conditions:
Date of Last Physical: / Date of TB Test:	Date of Last Physical: / Date of TB Test:
All persons living in the home will be required to take a TB test prior to licensure.	
Foster/Adopt History	
Applicant #1	**Applicant #2**
Have you ever previously applied to be a foster parent? ☐ Yes ☐ No	Have you ever previously applied to be a foster parent? ☐ Yes ☐ No
Name of Agency:	Name of Agency:
Date of Application:	Date of Application:
Have you ever been denied a foster care license or license renewal? ☐ Yes ☐ No	Have you ever been denied a foster care license or license renewal? ☐ Yes ☐ No
If yes, explain:	If yes, explain:
Is your home currently licensed, regulated, approved, or operated by any other agency? ☐ Yes ☐ No	Is your home currently licensed, regulated, approved, or operated by any other agency? ☐ Yes ☐ No
If yes, Name of Agency:	If yes, Name of Agency:
Previous Childcare Experience:	Previous Childcare Experience:

Alternate Caregiver

Details of who will provide childcare in case of an emergency. Background Check will be required.

First Middle Last	Relationship:
	Phone Number:
Address City State Zip Code County	
Email Address:	

Household Members

List anyone living in the home at any time during the year, including children and other family members, other than Applicants.

Household Member #1

First Middle Last	Gender : ☐ Female ☐ Male	
# of months they live in the home: ☐ > 6 Months/Year ☐ < 6 Months/Year ☐ All Year ☐ Other:	Relationship: ☐ Child ☐ Parent ☐ Sibling ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both ☐ Other:
Age:	Date of Birth:	Place of Birth:
Social Security Number:	Phone Number:	Email Address:
Any serious illness, handicap, chronic condition, or nervous condition(s)? ☐ Yes ☐ No		
If yes, please describe treatment and/or counseling:		

Household Member #2

First Middle Last	Gender : ☐ Female ☐ Male	
# of months they live in the home: ☐ > 6 Months/Year ☐ < 6 Months/Year ☐ All Year ☐ Other:	Relationship: ☐ Child ☐ Parent ☐ Sibling ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both ☐ Other:
Age:	Date of Birth:	Place of Birth:
Social Security Number:	Phone Number:	Email Address:
Any serious illness, handicap, chronic condition, or nervous condition(s)? ☐ Yes ☐ No		
If yes, please describe treatment and/or counseling:		

Household Member #3

First Middle Last	Gender : ☐ Female ☐ Male	
# of months they live in the home: ☐ > 6 Months/Year ☐ < 6 Months/Year ☐ All Year ☐ Other:	Relationship: ☐ Child ☐ Parent ☐ Sibling ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both ☐ Other:
Age:	Date of Birth:	Place of Birth:
Social Security Number:	Phone Number:	Email Address:
Any serious illness, handicap, chronic condition, or nervous condition(s)? ☐ Yes ☐ No		
If yes, please describe treatment and/or counseling:		

Household Member #4

First Middle Last	Gender : ☐ Female ☐ Male	
# of months they live in the home: ☐ > 6 Months/Year ☐ < 6 Months/Year ☐ All Year ☐ Other:	Relationship: ☐ Child ☐ Parent ☐ Sibling ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both ☐ Other:
Age:	Date of Birth:	Place of Birth:
Social Security Number:	Phone Number:	Email Address:
Any serious illness, handicap, chronic condition, or nervous condition(s)? ☐ Yes ☐ No		
If yes, please describe treatment and/or counseling:		

Please use an additional page if there are more Household Members than spaces provided.

Children Living Outside of Household

Please provide information regarding any children either Applicant have that live outside of the household, including adult children. House of Shiloh is required to obtain references from all of your children living outside of your household.

Child #1

First Middle Last	Gender: ☐ Female ☐ Male	
Age: Date of Birth: Place of Birth:	Relationship: ☐ Daughter ☐ Son ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both
Address City State Zip Code County		

Child #2

First Middle Last	Gender : ☐ Female ☐ Male	
Age: Date of Birth: Place of Birth:	Relationship: ☐ Daughter ☐ Son ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both
Address City State Zip Code County		

Child #3

First Middle Last	Gender : ☐ Female ☐ Male	
Age: Date of Birth: Place of Birth:	Relationship: ☐ Daughter ☐ Son ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both
Address City State Zip Code County		

Child #4

First Middle Last	Gender : ☐ Female ☐ Male	
Age: Date of Birth: Place of Birth:	Relationship: ☐ Daughter ☐ Son ☐ Other:	Related to: ☐ Applicant #1 ☐ Applicant #2 ☐ Both
Address City State Zip Code County		

Please use an additional page if there are more children than spaces provided.

References

Please list 3 persons or couples, not related to you, who have known you well for at least 3 years. Please try to vary the nature of your references. Additionally, please list one relative not already listed on this form that can provide a reference for you.

Reference #1

First Middle Last	Gender : ☐ Female ☐ Male	Relationship: ☐ Friend ☐ School ☐ Church ☐ Work ☐ Other:	
Address City State Zip Code County			
Cell Phone Number:	Home Phone Number:	Email Address:	Years Known:

Reference #2

First Middle Last	Gender : ☐ Female ☐ Male	Relationship: ☐ Friend ☐ School ☐ Church ☐ Work ☐ Other:	
Address City State Zip Code County			
Cell Phone Number:	Home Phone Number:	Email Address:	Years Known:

Reference #3

First Middle Last	Gender : ☐ Female ☐ Male	Relationship: ☐ Friend ☐ School ☐ Church ☐ Work ☐ Other:
Address City State Zip Code County		

Cell Phone Number:	Home Phone Number:	Email Address:	Years Known:

Relative Reference

First Middle Last	Gender : ☐ Female ☐ Male	Relationship: ☐ Friend ☐ School ☐ Church ☐ Work ☐ Other:
Address City State Zip Code County		

Cell Phone Number:	Home Phone Number:	Email Address:	Years Known:

I hereby declare that the information provided on this form to be true and complete to the best of my knowledge. I give my permission for any of this information to be verified and understand that if any of this information is found to be inaccurate or false, this may be used to terminate any further consideration of my application.

I authorize House of Shiloh Family Services to obtain any information that would assist in the evaluation of my application. As part of the House of Shiloh Family Services application and licensure process, House of Shiloh authorized personnel may request additional personal information from the applicant.

I hereby authorize House of Shiloh Family Services to contact any persons listed in this application, including, but not limited to family members, friends, employers, agencies, or companies.

Applicant #1 Signature:	**Date:**
Applicant #2 Signature:	**Date:**