

Dear Applicant(s):

Your decision to become a Foster Parent and share your lives with troubled youth is significant. Therefore, it is natural to have mixed feelings. Please review the following statements and see if any of them touch upon your feelings and concerns. Feel free to discuss them or any other concerns that you may have with us.

- Basically I feel uncertain. One minute I say "yes" and the next minute "no".
- I wonder if I will be happier or more satisfied as a Foster Parent than I am now.
- What if I try and fail?
- Will other members of my family be happier or more satisfied if we become a foster home or will it create problems?
- I wonder if becoming a foster parent will have a bad affect on my marriage.
- I wonder if I can afford to become a foster parent.
- I wonder if I'll be able to provide enough structure or balance between structure and freedom.
- I wonder if I'll really have enough time to give a foster child.

**Application Form Instructions:**

If you have made the decision to proceed with becoming a Foster Parent, the following forms and requirements need to be completed. Please use **black ink only**.

1. **Personal Information:**
2. **Screening Interview:** (You may add additional pages if necessary)
3. **Child Abuse & Neglect** check: DHS 1507 (CAN background check). Both parents if applicable, need to complete and sign this form and return in the self-addressed stamped envelope.
4. **Physical Examination:** The state requires a health report. You may need to have your doctor complete the Health Report (form D) or if you have had a physical with in one year a copy will do. All we need is a statement from your doctor that you are capable to undertake the care of foster children. In addition we need a TB **test** with in the last year. (You may get your TB test at the Wailuku Health Center, 121 Mahalani Street, next to the Cameron Center call 243-0532 to find the days and times. It is free and no appointment is necessary.
5. **Employment History Information:** Complete the top half only and sign it.
6. **Criminal History Record Clearance:** DHS 1645 (Criminal History check) complete and sign and return in the self-addressed stamped envelope. \*Criminal background checks are mandatory for ALL Adult members in the household.
7. **Fingerprinting:** Once all documents are turned in our HR Department will reach out with instructions on how to complete your fingerprinting.
8. **House Rules:** Every home must have a set of written house rules. Please list your rules. All house rules must be approved by MYFS and be in compliance with state regulations.
9. **Menu:** We are required to have at least one month's menu for breakfast lunch and dinner. The menu should reflect a variety of nutritious meals that incorporate all the basic food groups.
10. **Foster Parent Agreement**
11. **Foster Parent Reference:** This form will be sent out by the Foster Program staff to the 4 people you have listed as references.
  - ✓ Return all completed forms to Maui Youth & Family Svc. Foster Home Program PO Box790006 Paia, Hi. 96779
  - ✓ Upon receipt of your forms staff will contact you to arrange a meeting to discuss the program, home study, and other licensing requirements (ex. Training hours etc.)
  - ✓ The completion of licensing may take up to four meetings. Following approval you will be required to attend training prior to youth being placed in the home.

# Personal Information

Family Name: \_\_\_\_\_ Date of application: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number (s): \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number (s): \_\_\_\_\_

How were referred: \_\_\_\_\_

Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ How long? \_\_\_\_\_

## FAMILY BACKGROUND:

1. Parent 1's First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Religion/Church: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Monthly Income: \_\_\_\_\_ How long at present job? \_\_\_\_\_

Any previous marriages? \_\_\_\_\_

2. Parent 2's First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Religion/Church: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Monthly Income: \_\_\_\_\_ How long at present job? \_\_\_\_\_

Any previous marriages? \_\_\_\_\_

## OTHER ADULT IN THE HOUSEHOLD

1. Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**CHILDREN**

NAME	DOB	SCHOOL/OCCUPATION	LIVING IN HOME	
_____	_____	_____	Y_____	N_____
_____	_____	_____	Y_____	N_____
_____	_____	_____	Y_____	N_____
_____	_____	_____	Y_____	N_____

**FAMILY INFORMATION**

Why would your family like to become a Foster Home?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What experiences do you have working with young people?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What (and who) is your support system in case of emergencies?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you able to provide transportation to meetings and appointments?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any serious physical or psychiatric illnesses in the family in the past 5 years? Include physicians / psychiatrists names and length of treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has either applicant had any serious illness or chronic physical condition? If yes, please provide details.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does any household member have a criminal conviction (Felony, Misdemeanor) Y / N. If yes, list all convictions.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has any household member been reported to Child Protective Services or Adult Protective Services for Abuse or Neglect? Y / N  
Please give details.

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If you rent, please provide the owner's name, address, and phone number.

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Are there types of youth you would not accept? Y\_\_\_\_\_ N\_\_\_\_\_ (If Yes please describe.)

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Note areas that training could help your family with foster parenting.

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Note individual and family strengths that you feel could help a troubled youth.

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Aloha House/Maui Youth and Family Services/Malama Family Recovery Center

**Foster Home Program**

**Screening Interview**

(you may add additional pages if necessary)

1. Name: \_\_\_\_\_ Date: \_\_\_\_\_

2. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

3. Directions to your home: \_\_\_\_\_

\_\_\_\_\_

4. Client sex: Female Only \_\_\_\_\_ Male Only \_\_\_\_\_ Either \_\_\_\_\_

5. Number of clients at one time: \_\_\_\_\_

6. Sleeping Arrangements: \_\_\_\_\_

7. Able to provide transportation: Yes: \_\_\_\_\_ No: \_\_\_\_\_

When: \_\_\_\_\_

8. Work Schedules: \_\_\_\_\_

\_\_\_\_\_

9. Daily Routines: \_\_\_\_\_

\_\_\_\_\_

10. Other Activities: \_\_\_\_\_

\_\_\_\_\_

11. General Family Rules: \_\_\_\_\_

\_\_\_\_\_

12. Family Systems- decision making, anger, privacy, etc.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Own family history- physical or sexual abuse, drug or alcohol use: Support System: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Support System: \_\_\_\_\_

\_\_\_\_\_

15. Motivation for Foster Parenting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Prior Experiences with youth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Expectations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent #1

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent #2

\_\_\_\_\_  
Date

**STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION**

**INITIAL** OR  **RECERTIFICATION** PROGRAMS: CHECK ONE ONLY:

(\* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> CCFH/CMA (P)                  | <input type="checkbox"/> DOH-DDD  | <input type="checkbox"/> DHS-Med-QUEST (Other Than DOH- DDD)                               |
| <input type="checkbox"/> ACCS General (B)              | <input type="checkbox"/> DOH-CAMHD (Other Than Ther.Hms/Staff)  | <input checked="" type="checkbox"/> DOH-CAMHD- CPO Therapeutic Resource Homes & Staff (P)* |
| <input type="checkbox"/> ACCS Out-of-State Request (B) | <input type="checkbox"/> CWS- Hui Hoomalu & Kokua Ohana Staff (P)*  | <input type="checkbox"/> DHS-Office of Youth Services (Other Than Safe House Staff )       |
| <input type="checkbox"/> Adult Day Care Center (P)     | <input type="checkbox"/> CWS -CCI & CPO Staff & CPO non-therapeutic resources homes (P)*  | <input type="checkbox"/> DHS-Office of Youth Services Safe House Staff (P)*                |
| <input type="checkbox"/> Foster Grandparent (B)        | <input type="checkbox"/> CWS- Catholic Charities HI Hale Malama & HOPE Waiting Keiki Contract Resource Families (B)*                                  | <input type="checkbox"/> CWS Out-of-State Request for CAN Registry                         |
| <input type="checkbox"/> Senior Companion (B)          | <input type="checkbox"/> CWS Contracts-Other Than Already Noted (eg., CCSS, Ohana Conference, HAP, FSS, VCM, DV, Enhanced Healthy Start Title IV-B 2) | <input type="checkbox"/> CWS General   |
| <input type="checkbox"/> Respite Companion (B)         |   |  |
| <input type="checkbox"/> DOH-ADAD                      |   |  |
| <input type="checkbox"/> DOH-AMHD                      |   |  |
| <input type="checkbox"/> DOH-OHCA                      |   |  |

**AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY**

**REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)**

Name: Maui Youth & Family Services, Inc. Phone: (808) 579-8414  
 Address: P.O. Box 790006 ATTN: \_\_\_\_\_  
Paia, Hawaii 96779

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check:  **Adult Protective Services (APS)** and/or  **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. \* Programs with an asterisk-mail copy of results to requesting individual or agency and forward original to CWS FHL Unit noted on the bottom of page 2.

Full name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Any Alias(es)/Former Name, including Maiden Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until \_\_\_\_/\_\_\_\_/\_\_\_\_ or \_\_\_\_\_.  
 Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.**

\*\*\*\*\*FOR OFFICIAL USE ONLY\*\*\*\*\*

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**APS Central Registry Clearance: The following results are based upon the information provided on Page 1:**

**Type(s) of Confirmed Adult Abuse or Neglect:**

**Date(s) of Confirmation:**

- Caregiver Neglect (Negligent Treatment/Maltreatment)
- Financial Exploitation
- Physical Abuse
- Psychological Abuse
- Self-Neglect (Poor Self-Care)
- Sexual-Abuse

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

APS CHECK NOT REQUESTED                       NO RECORD OF CONFIRMED ADULT ABUSE ON FILE

**CAN Central Registry Clearance: The following results are based upon the information provided on Page 1:**

**Type(s) of Confirmed Child Abuse or Neglect:**

**Date(s) of Confirmation:**

- Physical Harm/Abuse
  - Failure to Thrive
- Threatened Physical Harm/Abuse
- Physical Neglect
  - Abandonment
  - Lack of Supervision
  - Medical Neglect
- Threatened Physical Neglect
- Sex Abuse
- Threatened Sex Abuse
- Psychological Harm
  - Abuse
  - Neglect
- Threatened Psychological Harm
- Providing a child with dangerous, harmful, or detrimental drugs as defined by Section 712-1240

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CAN CHECK NOT REQUESTED                       NO RECORD OF CONFIRMED CAN ON FILE

Clearance Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

DHS or Designee Worker's Name                      Phone Number

DHS-SSD-CWS: \*Mail copies of results to requesting agency and forward original results to CWS FHLU.  
 CWS FHL Unit Address: Department of Human Services  
 Foster Care Unit  
 1885 Main Street, Suite 306  
 Wailuku, Maui, HI 96793



**Aloha House/Maui Youth and Family Services/Malama Family Recovery Center  
Foster Home Program**

**Physical Examination**

**To Examining Physician:**

I have applied to Maui Youth and Family Services to become a licensed Foster Home. I request that the following information on my examination be given to this agency. This information is to help determine if my health is conducive to my caring for Foster Children.

\_\_\_\_\_  
Signature of Applicant

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Is this patient suffering from any chronic disease, handicapping illness or surgery that would be detrimental to working or caring for children? If yes, please

explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you consider this patient physically competent to undertake the care of youth? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EXAMINED BY: \_\_\_\_\_ DATE \_\_\_\_\_

Physician's Signature

**Aloha House/Maui Youth and Family Services/Malama Family Recovery Center  
Foster Home Program**

**Employment History**

I, \_\_\_\_\_ hereby give permission to \_\_\_\_\_  
Print Applicants Full Name Name of Employer

To furnish information about me, my work record and reputation to Maui Youth & Family services.

This information is to be used to assist the agency in determining my qualifications and fitness to become a Foster Home.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TO: \_\_\_\_\_ (Name of Manager / Supervisor or Human resources)

Employers Address: \_\_\_\_\_

Please complete the following questions and return within two weeks to:

Maui Youth & Family Service  
 Foster Home Program  
 P.O. Box 790006  
 Paia, Hi. 96779

\*\*\*\*\*

Thank you for your assistance in completing this form which will enable us to better assess the applicant for Foster Parenting and help us to better assess the needs of our children.

1. Has the applicant been employed by your organization? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes include Dates Employed: \_\_\_\_\_ Position Held \_\_\_\_\_

**STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION**

**PROGRAMS: CHECK ONLY ONE: (\* ITS: Forward form and print-out results to CWS FHLU-See page 2)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> CCFH/CMA (P)              | <input type="checkbox"/> DOH-CAMHD (Other Than Ther.Homes/Staff)   | <input type="checkbox"/> DHS-Med-QUEST (Other Than DOH- DDD)                         |
| <input type="checkbox"/> Adult Day Care Center (P) | <input type="checkbox"/> CWS- Child Specific Resource Families (B)*  | <input type="checkbox"/> DOH-CAMHD- CPO Therapeutic Resource Homes & Staff (P)*      |
| <input type="checkbox"/> Foster Grandparent (B)    | <input type="checkbox"/> CWS- Hui Hoomalu & Kokua Ohana Staff (P)*   | <input type="checkbox"/> DHS-Office of Youth Services (Other Than Safe House Staff ) |
| <input type="checkbox"/> Senior Companion (B)      | <input type="checkbox"/> CWS -CCI & CPO Staff & CPO non-therapeutic resources homes (P)*                             | <input type="checkbox"/> DHS-Office of Youth Services Safe House Staff (P)*          |
| <input type="checkbox"/> Respite Companion (B)     | <input type="checkbox"/> CWS- Catholic Charities HI Hale Malama & HOPE Waiting Keiki Contract Resource Families (B)* | <input type="checkbox"/> CWS- Hui Hoomalu DHS GL Resource Families (B)*              |
| <input type="checkbox"/> DOH-ADAD                  |  |  |
| <input type="checkbox"/> DOH-AMHD                  |  |  |
| <input type="checkbox"/> DOH-OHCA                  |  |  |
| <input type="checkbox"/> DOH-DDD                   |  |  |

**AUTHORIZATION FOR CRIMINAL HISTORY RECORD CLEARANCE**

- |  |               |  |   |   |
|--|---------------|--|---|---|
| <input type="checkbox"/> <b>FBI Fingerprinting Clearance</b> | <b>AND/OR</b> | <input type="checkbox"/> <b>Hawaii Criminal Justice Information System (CJIS)-Name Check</b> | <input type="checkbox"/> <b>Initial</b> | <input type="checkbox"/> <b>Recertification</b> |
|--|---------------|--|---|---|

**REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)**

Name: Maui Youth and Family Services, Inc. (MYFS) Phone: 808-579-8414  
Address: P.O. Box 790006 ATTN: \_\_\_\_\_  
Paia, Maui HI 96779

I hereby authorize the Department of Human Services (DHS) or its designee to conduct a criminal history record clearance on me and to release the information to the requesting individual or agency indicated above.

Full Name: \_\_\_\_\_  
Last First Middle

Any Alias(es)/Former Name(s), including Maiden Name: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Country of Citizenship: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Color eyes: \_\_\_\_\_ Color hair: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

I understand that the information I provide about me shall be used solely for the purpose of conducting the criminal history record clearance. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until \_\_\_\_/\_\_\_\_/\_\_\_\_ or \_\_\_\_\_.  
Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please check the appropriate box:**

- I have never been convicted of a crime.
- I have been convicted of the crime(s) listed below: (Do not include minor traffic violations involving a fine of \$50 or less)

Date and Place of Conviction	Offense	Sentence/ Fine

I, the undersigned, certify under penalty of false swearing in official matters, that the above listed information is true, accurate and complete to the best of my knowledge.

Print Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*FOR OFFICIAL USE ONLY\*\*\*\*\*

**FBI Fingerprinting Clearance: The following results are based upon the fingerprint results of the individual identified above:**

- No record of conviction found.  Record of conviction found.  FBI Fingerprint Clearance not requested

I certify that the Criminal History Record Check result information is accurate as of:

\_\_\_\_\_ Date of Fingerprinting

**Hawaii Criminal Justice Information System (CJIS) Name Check Clearance: (CWS FHLU will conduct CJIS Name Checks for programs with an asterisk)**

- No record of conviction found.  Record of conviction found.  CJIS Clearance not requested

I certify that the Criminal History Record Check result information is accurate as of: \_\_\_\_\_

Date of CJIS Name Check

Clearance Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
DHS or Designee Worker's Name Phone Number

DHS-SSD-CWS: \*Forward this Form and print out results to CWS FHLU (see below):

CWS FHL Unit Address:

**Department of Human Services  
 Foster Care Unit  
 1885 Main Street, Suite 306  
 Wailuku, Maui, HI 96793**

**Aloha House/Maui Youth and Family Services/Malama Family Recovery Center  
Foster Home Program**

**House Rules** (You may add additional pages if necessary)

Name of Foster Parent: \_\_\_\_\_

Please list the house rules or any additions.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

You may send in your own copy or use this form. All rules must be approved by MYFS and be in compliance with State Regulations.

Aloha House/Maui Youth and Family Services/Malama Family Recovery Center  
**Foster Home Program**

**Menu**

Week 1	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>Breakfast</b>							
<b>Lunch</b>							
<b>Snack</b>							
<b>Dinner</b>							

**Aloha House/Maui Youth and Family Services/Malama Family Recovery Center**  
**Foster Home Program**

**Foster Parent Agreement**

As a foster parent with Maui Youth and Family Services I understand the following:

1. Foster Parents will maintain a clean well furnished, well equipped home suggestive of family pride, industry, and maintenance. This includes the yard.
2. Foster Parents will provide a daily schedule for the home and each individual child, reflecting organizational ability, attention to punctuality in appointments and scheduling of daily life to allow adequate time for personal hygiene, chores, school or work assignments, nutritional, and tasty meals, transportation to scheduled activities and meetings.
3. Foster parents provide opportunities for religious observance in the faith of the youth's choice and participation in activities consistent with the youth's ethnic and cultural heritage.
4. Foster Parents are to support program treatment plans and procedures, participate in training's, and meetings, weekly meetings with the counselor and child to set up behavioral contracts.
5. Where possible Foster Parents are encouraged to participate in discussion with natural or replacement families to help pass on important information in raising these children and modeling of parenting techniques to parents who may lack them or need encouragement and example in building parental skills.
6. Foster Parents are responsible for gathering data as requested to help identify and prioritize treatment goals. As noted previously, they participate with the counselor in the production of weekly behavioral goals and meet with the child to note progress and problems.
7. Foster Parents will keep a written record of appointments, activities, phone calls, visitations, incidents, and changes.
8. Foster Parents will provide allowance as appropriate.
9. Foster Parents have the primary responsibility for implementing in home treatment strategies as part of the overall treatment plan under the supervision of the counselor.
10. Foster parents provide strong supervision, maintaining clients within sight or sound during waking hours except for privileges accorded or earned by cooperation and performance of contracts. Children are never left home without adult supervision and when left off for appointments, the Foster Parent will verify there is an adult available to take charge. (The only exception to this is home passes).
11. Foster Parents have the primary responsibility for enrollment in, communication with, transportation to, and advocacy with the school.
12. Foster Parents provide strong support and encouragement of academic training, encouraging the youth to read and write on a daily basis, to attend school or tutorial assignments promptly and prepared with homework, assign quiet time for production of homework. Monitor school attendance daily.
13. Foster Parents will ensure protection of their children from inappropriate outside influences (adult or peer) by monitoring such relationships, keeping a record of phone calls, and meeting and approving any visitors or companions on activities without adult supervision. In the event of others driving the child, the Foster Parents will ascertain proof of current driver's license, insurance and safety check on the vehicle, ensuring that no drivers under 18 are allowed to transport our clients in their vehicle.
14. Foster parents understand that the following practices are prohibited forms of punishment/ consequences for the foster youth and agree not to use these forms of punishment/ consequences:
  - a. Degrading punishment
  - b. Corporal punishment
  - c. Withholding of nutrition or hydration
  - d. Infliction of physical or psychological pain
  - e. Forced physical exercise solely for the purpose of eliminating behavior without instructive or athletic value

- f. Punitive work assignments
  - g. Group or peer punishments for one person's behavior
  - h. the use of demeaning, shaming, or degrading language or activities
  - i. unnecessarily punitive restrictions
  - j. Medication for punishment
  - k. Involuntary isolation
  - l. Deprivation of rights
  - m. Painful aversive stimuli
  - n. Chemical, Physical or mechanical restraint
15. Foster Parents will open mail with the client and make search of the youth's property if it is suspected they are in possession of contraband, or material deemed harmful to the client's welfare.
  16. Foster Parents will exercise respect and caution in touching client's so as not to raise any questions of impropriety in either violent or sexual touching. There will be no improper relationship between Foster Parents and the children entrusted to them. Violations will be reported to authorities including police and/or DHS officials.
  17. All information, including medical information regarding a client is confidential and will be kept in strictest confidence.
  18. If property damage, household infractions, major rule violations, accidents, or injuries occur, the Foster Parents will document the incidents on proper forms.
  19. In the event of accident or injury the Foster Parent will obtain immediate appropriate medical care.
  20. Prudence will be shown caring for children such that fire safety equipment (fire extinguisher and smoke detector) are available. Steps should be taken to go over fire exits and procedures in the event of a fire. There should be monthly evaluation of the fire equipment to insure that it is working properly.
  21. All medication will be kept locked up and medication charts will be maintained for usage.
  22. Any drinking in the house is minimal and only by those over the age of 21. There will be no use of drugs except under doctor's orders.
  23. Foster Homes are subject to visitation by staff and personnel from other agencies, usually with prior arrangement.
  24. Program staff will be available to foster parents 24/7 by telephone for support and guidance.
  25. Foster parents will receive an appropriate stipend for each day a youth is in their care based on type of placement.
  26. Foster parents will receive training and education to improve skills.

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Foster Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff

\_\_\_\_\_  
Date



**Aloha House/Maui Youth and Family Services/Malama Family Recovery Center  
Foster Home Program**

**Foster Parent Reference Form**

To: \_\_\_\_\_

\_\_\_\_\_ has applied to become a Foster Parent for Maui Youth & Family Service and identified you as a reference. Your responses to the following questions will be considered confidential in every respect. Please answer all questions as honestly as possible. Your time and effort in providing this information is appreciated. Please print your Mailing Address:

\_\_\_\_\_ Phone: \_\_\_\_\_

1. How long have you known the applicant(s)? \_\_\_\_\_  
\_\_\_\_\_
2. How well do you know the applicant(s) & in what capacity? \_\_\_\_\_  
\_\_\_\_\_
3. How would you describe the applicant(s) ability to handle highly emotional situations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. How does the applicant(s) respond to rapidly changing situations?( use examples) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Describe how the applicant responds to being agitated, angry, or upset? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Would you feel comfortable leaving your child or a child close to you in the applicants home? (If no explain) \_\_\_\_\_  
\_\_\_\_\_
7. Do you know of any instances of drug use or excessive use of alcohol? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. How would you assess the applicant(s) personal ethics? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. To your knowledge has the applicant(s) ever been physically or verbally abusive? (If Yes please explain). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Describe which aspect of foster parenting you think would be the most difficult for the applicant(s) to handle? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. What do you think are the applicant's greatest strengths? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Please rate the applicant(s) on each of the following characteristics with respect to their ability to be Foster Parents:

	NEVER	SOME-TIMES	OFTEN	ALWAYS	DON'T KNOW
Works cooperatively with others					
Understands others point of view					
Establishes rapport easily					
Respects cultural differences					
Patient					
Encouraging					
Has realistic expectations of children					
Nurturing					
Accepts criticism easily					
Follows through on tasks					
Can recognize emergency situations					
Sensitive to feelings of others					
Ability to anticipate consequences					
Flexible					
Communicates own feelings					
Reserved					
Shy					
Outgoing					
Authoritarian					
Laid back					
Expresses anger to others					
Demonstrates high self worth					

Thank you for helping us to better serve the needs of Hawaii's youth & families. Please this completed form to:  
 Maui Youth & Family Services  
 P.O. Box 790006  
 Paia, HI 96779

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date