GUIDELINES FOR ADOPTION APPLICANTS

1. _______ Complete the "Adoption Application."
2. _______ CHS 1018 Consent to Participate in Adoption Services
3. _______ Sign the "DCF Release of Information Form."
4. _______ Sign the "DCF Confidentiality Agreement" (Keep one copy).
5. _______ Read "A Guide to Complaint & Grievance Reporting Procedures."
   Sign the "Complaint Investigation Procedures" receipt.
6. _______ Complete "Financial Security Determination." 2 years W-2s (or tax returns)
7. _______ Not U.S. born, documentation: Passport/Green Card/Citizenship Papers
8. _______ Complete and sign the "Central Abuse Hotline Record Search."
9. _______ Sign the "Local Law Enforcement Check" release (per person age 18 & over).
10. _______ Sign Palm Beach County Sheriff’s Department release (per person 18 & over).
11. _______ Age 12-17, Complete the "Request for FDLE Criminal History Information."
12. _______ Age 18 & over, Complete the "Live Scan Information Form."
13. _______ Sign the "Acknowledgement of Firearms Safety Requirements."
14. _______ Reference Contact Information (minimum 5).
15. _______ Return of Physical Exam & Health Certificate (completed by your Dr.).
16. _______ Provide a copy - Marriage Certificate & divorce verification (if applicable).
17. _______ Children not Residing in the Home Form (if applicable).

Children's Home Society of Florida * 3333 Forest Hill Blvd., West Palm Beach, Fl 33406
(561) 868-4300 * Fax (561) 868-4496

Jill Ortiz, BS
Adoption Recruiter
561-868-4312

Amy Garvin-Liddell, MSW, LCSW
Post Adoption Specialist
561-868-4321

Nicole (Nikki) Redford, BA
Adoption Recruiter
561-868-4343

Briana Calzada, BSW
Adoption Specialist
561-868-4363

Jessica Norse, B.A.
Adoption Specialist
561-868-4339

Richard Miller, BS
Adoption Specialist
561-868-4346

Elizabeth (Betty) Phelps, B.S.
Adoption Specialist
561-868-4303

Eileen Kreitzman, B.S.
Adoption Specialist
561-868-4464

Harriet Zeikowitz, MS, LMHC
Adoption Specialist
561-868-4325
ADOPTIVE HOME APPLICATION

Prospective Parent 1 Name (first, middle, last):

Prospective Parent 2 Name (first and maiden):

I. CURRENT SITUATION

A. RESIDENCE: Address: __________________________________________________________________________________________
   (Number and Street) __________________________ (City) ________ (County) ________ (State) ________ (Zip Code) ________
   Telephone Number(s): __________________________ __________________________ __________________________
   (Home Number) __________________________ (Work Number) __________________________ (Cell Number) ________
   E-mail: __________________________________________________________________________________________
   How long at this address: ________ Number of Rooms: ________
   Check One: ☐ House Check One: ☐ Own Monthly Payment: $_____
   ☐ Apartment ☐ Rent Mortgage Balance: $_____
   If less than 3 years at above address, list former addresses for 5 years.

B. PRESENT MARRIAGE: Date of Present Marriage: __________________________ Attach copy of marriage certificate.
   (If applicable) ______________________________________________________________________________________
   Describe briefly any separations, including dates and duration. ☐ Copy attached

List children of Present Marriage
Child’s Name: ____________________________________________________________
Child’s Date of Birth: __________________________ Natural or Adopted: __________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C. Name of Others in Home
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

D. Prospective Parent 1
Religious Affiliation: ______________________________________________________

Prospective Parent 2
Religious Affiliation: ______________________________________________________
E. INTERESTS:  

Prospective Parent 1  
Prospective Parent 2  

Community (clubs, lodges, etc.)  

Hobbies or Special Interests  

F. HEALTH: Attach completed physician’s reports for both adults, if a physical is necessary.  
☐ Report Attached  

G. EMPLOYMENT: If current employment is less than 3 years, list former employment for 10 years.  

Prospective Parent 1  
Prospective Parent 2  

Current Employment  

Prior Employment (if applicable)  

H. FINANCIAL STATUS – ASSETS:  

Prospective Parent 1  
Prospective Parent 2  

| INCOME | Gross Yearly Salary | Interest or Dividends | Rental Income | Other |  
|        |  |  |  |  |  
| CAPITAL | Real Estate at Market Value | Savings | Other Investments (list on separate sheet and attach to this application) |  |  
|        |  |  | (list on separate sheet and attach to this application) |  |  
| INSURANCE | Life | Accident | Hospitalization | Other (specify) |  
|        |  |  |  |  |  

FINANCIAL STATUS – LIABILITIES: Itemize on separate sheet and indicate payment plan. Attach sheet to this application.  

Debts Totaled  
Exclude home mortgage.  

Other Obligations  

## II. LIFE HISTORY

### A. Prospective Parent 1
- **Birthdate:**
- **Birthplace:**

### Prospective Parent 2
- **Birthdate:**
- **Birthplace:**

### B. RACE/ETHNICITY:
- **Prospective Parent 1:**
  - White
  - Black or African American
  - Hawaiian or Pacific Islander
  - Hispanic
  - Asian
  - American Indian or Alaskan Native
  - Other

- **Prospective Parent 2:**

### C. EDUCATION:
- Last Grade Completed or Degree
- Special Training, if any

### Prospective Parent 1

### Prospective Parent 2

### D. MEDICAL HISTORY — PHYSICAL and PSYCHIATRIC — MAJOR MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th>Condition Treated for</th>
<th>Date Treated</th>
<th>Inpatient or Outpatient</th>
<th>Place Treated</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
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<td>Prospective Parent 1</td>
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<td>6.</td>
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<tr>
<th>Condition Treated for</th>
<th>Date Treated</th>
<th>Inpatient or Outpatient</th>
<th>Place Treated</th>
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<tr>
<td>Prospective Parent 2</td>
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<td>6.</td>
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### E. PREVIOUS MARRIAGES: Attach documentation of death or divorce.

<table>
<thead>
<tr>
<th>Previous Spouse's Name</th>
<th>Date and Place Married</th>
<th>Date and Place Marriage Terminated</th>
</tr>
</thead>
</table>

### Prospective Parent 1

### Prospective Parent 2

### Children of Previous Marriage:

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Age</th>
<th>Whereabouts</th>
<th>Support Payments</th>
<th>Describe continuous contact if out of home</th>
</tr>
</thead>
</table>

### Prospective Parent 1

### Prospective Parent 2
F. ARREST RECORD: (violations of law other than minor traffic violations)

Prospective Parent 1: [ ] Yes [ ] No
Civil Rights Restored? Prospective Parent 1: [ ] Yes [ ] No
Prospective Parent 2: [ ] Yes [ ] No

If either prospective parent has an arrest record, provide details below:

<table>
<thead>
<tr>
<th>Prospective Parent’s Name</th>
<th>Where Arrested</th>
<th>Date Arrested</th>
<th>Nature of Charge</th>
<th>Disposition</th>
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III. REFERENCES (two must be non-relatives)

Name
Prospective Parent 1 Employer

Address

Telephone Number

Prospective Parent 2 Employer


IV. ADOPTION

Do you know anyone well who is adopted? [ ] Yes [ ] No If yes, who?____________________ Have you ever applied to adopt a child from another source? [ ] Yes [ ] No If yes, when?______________

What source?________________________________________

What children would you like us to consider for your family (age, sex, siblings, disabilities, etc.)?

What children would you not like us to consider for your family (age, sex, siblings, disabilities, etc.)?

I understand the importance of providing complete information and attest that the information provided above is accurate to the best of my knowledge. I understand, in accordance with Section 837.06, Florida Statutes, that making false statements in writing with the intent to mislead a public servant in the performance of his official duty is a misdemeanor of the second degree, punishable as provided in Sections 775.082, 775.083, or 775.084, Florida Statutes.

__________________________  __________________________  _________
Prospective Parent 1 Signature  Prospective Parent 2 Signature  Date Signed
ADOPTIVE HOME APPLICATION

(All information herein is strictly confidential.)

Date: ____________________________

I, We

Prospective Parent 1 First Name ___________________ Middle Name ___________________ Last Name ___________________

Prospective Parent 2 First Name ___________________ Middle Name ___________________ Last Name ___________________

Residing at ____________________________________________

County: ____________________________________________

Have read and understand the following:

IMPORTANT NOTE: Pursuant to the Multi-Ethnic Placement Act of 1994 and the Small Business Job Protection Act of 1996, Section 1808, "Removal of Barriers to Interethnic Adoption," race, culture or ethnicity may not be used as the basis for any denial of placement, nor may such factors be used as a reason to delay a foster or adoptive placement. Discrimination is not to be tolerated, whether it is directed toward adults who wish to serve as foster or adoptive parents, toward children who need safe and appropriate homes, or toward communities or populations that may previously have been under-utilized as a resource for placing children.

______________________________
Prospective Parent 1 Signature

______________________________
Prospective Parent 2 Signature
CONSENT AND FAMILY AGREEMENT TO PARTICIPATE IN ADOPTION SERVICES PROVIDED BY THE CHILDREN’S HOME SOCIETY OF FLORIDA

I agree for my family to participate in services provided by The Children’s Home Society of Florida ("CHS") in their Adoption Program. I understand that the services my family participates in may last for up to _____ months and that during that time I will be visited by or visit with

(Enter projected months of service)

(Enter type of staff providing services: i.e. case manager, counselor, social worker, Family Builder team, therapist)

I agree to cooperate with these professionals, to take an active part in the development of my family’s service plan, and to work toward my family goals by doing the tasks outlined in the service plan in order to accomplish my family’s stated objectives.

Family members who will participate in services are:

(First & Last Name) (Date)

(First & Last Name) (Date)

(First & Last Name) (Date)

(First & Last Name) (Date)

(First & Last Name) (Date)

(First & Last Name) (Date)

I understand that I will be requested to sign a separate Consent or Authorization For Release of Confidential Information to Another Organization (CHS1017 Form B (Adop)) for CHS to release information to the referring agencies.

This consent or authorization for release of information shall be effective the date of signature and shall expire:

(check one) ☐ ninety (90) days from the date of signature for a one time release of information OR ☐ one (1) year from the date of signature for ongoing service provision.

(Signature of responsible head of family) (Date)

(Signature 2nd adult family member, if appropriate) (Date)

(Signature of Witness) (Date)

If the consumer has difficulty understanding or reading this document, please print the name of the person who read this document or explained it to the consumer: ________________________________.
RELEASE OF INFORMATION

I(we) hereby authorize the release of any information requested by the Department of Children and Families to be utilized in determining my(our) suitability to become

☐ a licensed out-of-home caregiver, or  ☐ an adoptive parent.

I(we) hereby grant permission to the Department of Children and Families to obtain information from local, state, or federal law enforcement agencies to help determine my(our) suitability to serve as a foster parent or as an adoptive parent. I(we) understand, however, that a history of arrest reported by any of these agencies will not necessarily prohibit my(our) participation in

☐ the licensed out-of-home care program, or  ☐ the adoption program.

Pursuant to Florida Statute 39.202(2)(a)5., I(we) hereby authorize the Department of Children and Families to make inquiry of the central abuse registry and tracking system in regard to the existence of any confirmed report of abuse, neglect, or exploitation and the results of any investigation pursuant hereto.

---

Applicant ____________________________ Date ____________________________

Applicant ____________________________ Date ____________________________

Adult Household Member ____________________________ Date ____________________________

Adult Household Member ____________________________ Date ____________________________

NOTE: All adult members (age 18 and over) of the household will be responsible for granting consent to these record checks.
CONFIDENTIALITY AGREEMENT

I understand and agree that all information as it relates to child abuse records and clientele are to be held confidential in compliance with the Child Abuse Statute, Florida Statute 39.205 which states "any person who willfully or knowingly makes public or discloses any information contained in the child abuse registry or the records of any child abuse case except as provided in this section is guilty of a misdemeanor of the second degree."

I further agree to treat any such information on clients that should come to my attention and knowledge as privileged and confidential, and that I will not disclose such information to anyone other than authorized persons.

__________________________________________  ______________________________
Date                                           Signature

__________________________________________  ______________________________
Witness                                        Signature

This will acknowledge that I have received a copy of this document.

__________________________________________  ______________________________
Date                                           Signature

__________________________________________
Date                                           Signature
CONFIDENTIALITY AGREEMENT

I understand and agree that all information as it relates to child abuse records and clientele are to be held confidential in compliance with the Child Abuse Statute, Florida Statute 39.205 which states “any person who willfully or knowingly makes public or discloses any information contained in the child abuse registry or the records of any child abuse case except as provided in this section is guilty of a misdemeanor of the second degree.”

I further agree to treat any such information on clients that should come to my attention and knowledge as privileged and confidential, and that I will not disclose such information to anyone other than authorized persons.

Date ______________ Signature __________________

Witness __________________ Signature __________________

This will acknowledge that I have received a copy of this document.

Date ______________ Signature __________________

Date ______________ Signature __________________
A GUIDE TO COMPLAINT & GRIEVANCE REPORTING PROCEDURES

For Consumers of the Department of Children & Families
Licensed Adoption Agencies & Child Placing Agencies

Which Child Placing Agencies Must be Licensed by the Dept of Children & Families in District 9?

* All agencies placing children in foster homes or residential child caring facilities.
* All adoption agencies located in Palm Beach County.
* Not attorneys that provide adoption legal services.
* Not doctors that provide adoption services.
* Not adoption referral services that recommend adoption resources.

How to Report your Complaint to the Department of Children & Families

We accept your complaints reported by phone. Call 561-837-5078
Or you may address your complaints in writing to:
Department of Children & Families - Client Relations Coordinator
1111 South Sapodilla Ave., West Palm Beach, FL 33401

Complaint Investigation Procedures

1. Licensing staff of the department may make scheduled or unannounced visits to a licensed home, facility or agency at any reasonable time to investigate compliance with the licensing requirements. All agencies shall be inspected at least annually.
2. The department shall investigate complaints to determine if the agency is meeting the licensure requirements.
3. The department shall advise the owner and operator with authority over the licensed agency that there is a licensing complaint when initiating an investigation and shall advise the agency of the results when the investigation is concluded.
4. Whenever the department receives a report questioning the certification status or compliance of a child placing agency with requirements of the state adoption law or alleging violation of this chapter by the agency, the department shall investigate the allegation within 20 working days to determine whether the complaint is substantiated.
5. The department shall notify the complainant and the agency in writing of the results of the complaint investigation within 15 working days after the report of the department's investigation has been finalized.
6. The agency shall fully cooperate with the department whenever such complaint investigations are conducted.

District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120

Working in partnership with local communities to help people be self-sufficient and live in stable families and communities.
COMPLAINT INVESTIGATION PROCEDURES

By my signature below, I verify that I have received and reviewed "A Guide To Complaint and Grievance Reporting Procedures" for consumers of Florida Department of Children & Families Licensed Adoption Agencies and Child Placing Agencies.

Signature                                      Date

Signature                                      Date

Note: The original of this page must be kept on file at the agency.

District 9, Dimick Building, Family Safety & Preservation
111 South Sapodilla Avenue, West Palm Beach, Florida 33401
(561) 837-5120

Working in partnership with local communities to help people be self-sufficient and live in stable families and communities.
# Financial Security Determination

<table>
<thead>
<tr>
<th></th>
<th>Caregiver 1</th>
<th>Caregiver 2</th>
<th>Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td>Combined Monthly Income $</td>
</tr>
<tr>
<td>Current Employer</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Employer's Address</td>
<td></td>
<td></td>
<td>Expenses $</td>
</tr>
<tr>
<td>Length of Current Employment</td>
<td></td>
<td></td>
<td>* Housing $</td>
</tr>
<tr>
<td>Hours &amp; Shifts Worked</td>
<td></td>
<td></td>
<td>* Utilities $</td>
</tr>
<tr>
<td>Gross Yearly Salary</td>
<td>$</td>
<td></td>
<td>* Transportation/Gas $</td>
</tr>
<tr>
<td>Net Take Home</td>
<td>$ weekly $ biweekly</td>
<td>$ weekly $ biweekly</td>
<td>* Food / Supplies $</td>
</tr>
<tr>
<td>OR $ monthly</td>
<td>OR $ monthly</td>
<td>OR $ monthly</td>
<td>* Medical $</td>
</tr>
<tr>
<td>Medicaid Eligible</td>
<td></td>
<td></td>
<td>* Child Care $</td>
</tr>
<tr>
<td>Additional Support or Income</td>
<td></td>
<td></td>
<td>* Car Payment $</td>
</tr>
<tr>
<td>* Social Security Benefits</td>
<td></td>
<td></td>
<td>* Car Insurance $</td>
</tr>
<tr>
<td>* Retirement Benefits</td>
<td></td>
<td></td>
<td>* Credit Cards $</td>
</tr>
<tr>
<td>* Wages (Temp, Case Assistance)</td>
<td></td>
<td></td>
<td>* Other Bills (list below) $</td>
</tr>
<tr>
<td>* Disability Benefits</td>
<td></td>
<td></td>
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<tr>
<td>* Others (list)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td>TOTAL MONTHLY EXPENSES $</td>
</tr>
</tbody>
</table>

Will child care or after-school care be needed? ( ) Yes ( ) No How will it be provided?

What new expenses are anticipated for the child(ren) to be placed in the home?

Health Insurance Coverage? ( ) Yes ( ) No Name of Insurance Company

$ of Workman's Compensation Insurance Husband $ Wife $ Name of Companies None( )

Amount of Life Insurance Husband $ Wife $ Name of Companies None( )

Please describe any debt or bills that are causing a problem for you at this time.

How would you handle a financial situation if the subsidy check failed to arrive when expected.

Father's Signature Mother's Signature Date
Central Abuse Hotline Record Search

If we, ___________________________ and ___________________________, as an applicant for adoption, an applicant for licensing/registration, or a DCF employee, authorize a search for reports of abuse, neglect or abandonment investigated pursuant to Chapter 39, Florida Statutes in which my name appears and there were "verified indicators" of maltreatment of a child(ren). I understand I will be given the opportunity to discuss the findings of the report(s). I further understand that the central abuse hotline search is only one part of the preliminary report to the court for adoption, one of the requirements reviewed by an agency with the authority to license or approve homes for the care of develop-mentally disabled persons and children, including family child care homes and facilities, or for DCF employment. This consent is valid solely for the requesting agency/facility listed below on this form.

Applicant Signature: ___________________________ Date: ___________ Phone: ___________
Print name legibly on line, then affix signature

Spouse Signature: ___________________________ Date: ___________ Phone: ___________

NOTE: This form must be submitted by one of the agencies identified at the bottom of this page. The applicant/spouse may NOT SUBMIT THIS FORM DIRECTLY to the Department of Children & Families.

Applicant: SSN: _______ DOB: _______ Race: _______ Sex: _______

Spouse: SSN: _______ DOB: _______ Race: _______ Sex: _______ Prior Name(s): _______

Current Address: Address: ___________ City: ___________ County: ___________ State: ___________ Zip: ___________ Dates at Address: ___________

Previous Address: Address: ___________ City: ___________ County: ___________ State: ___________ Zip: ___________ Dates at Address: ___________

Reason for Record Search: ☐ Adoption Applicant (Chapter 63) ☐ DCF Employee (Chapter 39)
☐ Licensing/Registration Applicant (Chapters 39, 415, 402 or 409)

(NOTE: Searches of the Central Abuse Hotline may not be used for any employee except those working for DCF.)

Family child care, foster/shelter/group home or adoption applicants must list all child and adult household members on page two of this form. Do not include any foster care children.

TO BE COMPLETED BY REQUESTING AGENCY

☐ Child Care Center ☐ Family Child Care Home ☐ Foster/Shelter/Small Group Home ☐ Adoption
☐ Child-Caring Agency ☐ Child-Placing Agency ☐ DD Foster/Shelter/Small Group Home

OCA and/or Facility ID: ______________________________________

Facility/Agency Name: ___________________________ Phone: ___________

Address: ______________________________________ Mailing Address: ___________
City: ___________ Zip: ___________

I understand it is a misdemeanor of the first degree for any agency to use or release abuse, neglect or abandonment information to others. The information is CONFIDENTIAL and may be used only for the purpose for which it was obtained.

Printed Name and Signature of Requesting Facility/Agency Representative: ___________________________ Date: ___________

CF 1651, PDF 11/2008
Central Abuse Hotline Record Search

APPLICANTS FOR FAMILY CHILD CARE, FOSTER/GROUP HOME OR ADOPTIONS – PLEASE ENTER INFORMATION FOR ALL CHILD AND ADULT HOUSEHOLD MEMBERS *EXCEPT FOSTER CHILDREN.*

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>DOB</th>
<th>Race</th>
<th>Sex</th>
<th>SSN</th>
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RESULTS (Department or Agency Conducting Search Use Only)

☐ No records found with verified findings where the applicant was the caretaker responsible in the final role or, for licensing, in any role in three reports within a five year period.

☐ Records found for review are listed below:

<table>
<thead>
<tr>
<th>Report Number</th>
<th>Report Date</th>
<th>County</th>
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Date of Search:______________

Employee Conducting Search: ___________________________ Phone: ___________________________  Signature
CHILDREN'S HOME SOCIETY OF FLORIDA
Request for Local Law Enforcement Check for Adoption Applicant

Date _____ / _____ / _____

Local Law Enforcement Check

Pursuant to Chapter 85-54, F.S., Children's Home Society of Florida requests a local records check on the applicant listed below, as well as notification of any and all contacts your department has had with this applicant.

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Please document the findings on this check and return the information to:

Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

Sincerely,

Children's Home Society of Florida

The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

I hereby authorize _____________________________ to check any and all records pertaining to the criminal arrests and convictions, and for any law enforcement agency to release to Children's Home Society of Florida information regarding arrests and convictions and any and all contacts the applicant has had with said agency, under Florida statutes or statutes of any other jurisdiction.

Date _____ / _____ / _____

APPLICANT FOR ADOPTION SIGNATURE
Children's Home Society of Florida

Request for Local Law Enforcement Check for Adoption Applicant

Date _____ / _____ / _____

Local Law Enforcement Check

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LAST NAME   FIRST NAME   MIDDLE

MAIDEN   OR   A.K.A

_____ / _____ / _____  RACE  _____  SEX  SOCIAL SECURITY #

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CHILDREN'S HOME SOCIETY OF FLORIDA

Request for Local Law Enforcement Check for Adoption Applicant

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Children's Home Society of Florida - South Coastal Division
3333 Forest Hill Blvd., West Palm Beach, FL 33406

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The Children's Home Society currently has a contract with the Department of Children & Families to complete home studies for the Department's adoptive applicants. We are requesting that you process the background screenings without charging a fee.

I hereby authorize PALM BEACH COUNTY SHERIFF’S OFFICE to check any and all records pertaining to the criminal arrests and convictions, and for any law enforcement agency to release to Children's Home Society of Florida information regarding arrests and convictions and any and all contacts the applicant has had with said agency, under Florida statutes or statutes of any other jurisdiction.

Date _____ / _____ / ______  APPLICANT FOR ADOPTION SIGNATURE
CHILDREN'S HOME SOCIETY OF FLORIDA  
Request for Local Law Enforcement Check for Adoption Applicant

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DOB           RACE       SEX       SOCIAL SECURITY #

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3333 Forest Hill Blvd., West Palm Beach, FL 33406

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Date        /        /        

APPLICANT FOR ADOPTION SIGNATURE
REQUEST FOR FDLE CRIMINAL HISTORY INFORMATION

TO: Applicant Section  
   User Service Bureau  
   FDLE  
   Post Office Box 1489  
   Tallahassee, FL 32302

FACILITY NUMBER: __503139____

FROM: _____________________________
   (name of requester)

   Children's Home Society of Florida
   (mailing address)

   3333 Forest Hill Blvd.
   West Palm Beach, FL 33406

   Phone Number: (561) 868-4300

The more complete this information is, the better the search and associated results will be. PLEASE TYPE OR PRINT CLEARLY.

Applicant Name: ____________________________

Other names applicant has used (include maiden names and nicknames)

________________________________________

Race: (circle one) Black White Asian  
Alaskan Native American Indian  
Unknown

Sex: (circle one) Male Female  

DOB: ______________

Social Security Number: ____________________

Address: __________________________________

__________________________________________________________________________

I certify that the person listed above is a volunteer or a caretaker employee requiring a five-year re-screening. I understand that the Legislature has established a reduced payment of $8.00 for the criminal history checks of these persons.

   (signature of owner or on-site director)  (date)
REQUEST FOR FDLE CRIMINAL HISTORY INFORMATION

TO: Applicant Section
User Service Bureau
FDLE
Post Office Box 1489
Tallahassee, FL 32302

FACILITY NUMBER: 503139

FROM:   
(name of requester)

Children's Home Society of Florida
(mailing address)
3333 Forest Hill Blvd.
West Palm Beach, FL 33406

Phone Number: (561) 668-4300

The more complete this information is, the better the search and associated results will be.
PLEASE TYPE OR PRINT CLEARLY.

Applicant Name:   

Other names applicant has used (include maiden names and nicknames)

Race: (circle one) Black White Asian American Indian Alaskan Native Unknown

Sex: (circle one) Male Female DOB: 

Social Security Number:

Address: 

I certify that the person listed above is a volunteer or a caretaker employee requiring a five-year re-screening. I understand that the Legislature has established a reduced payment of $8.00 for the criminal history checks of these persons.

(signature of owner or on-site director) (date)
Please fax to The Foster and Adoptive Parents Association at 352-2544 and call 352-2540 to schedule your fingerprint appointment. A fingerprint check is requested from adult persons who have not been licensed and thoroughly screened by the Department of Children and Families. This is to safeguard that a child is not left in the care of someone who may have criminal charges found in Florida Statute 435.045 or any other charges, which may indicate a potential risk to a child.

LIVE SCAN INFORMATION FORM

NAME: ____________________________
ALIASES: __________________________
SS#: ______________________________
DOB: ______________________________
PLACE OF BIRTH: __________________
COUNTRY OF CITIZENSHIP: __________
HOME ADDRESS: ____________________

CIRCLE ONE: GENDER - M or F

CIRCLE ONE: RACE - A - ASIAN
B - BLACK
I - NATIVE AMERICAN
W - CAUCASIAN / LATINO

EYE COLOR: ________________
HAIR COLOR: ________________
DRIVERS LICENSE # __________________________
EMPLOYEE NAME AND ADDRESS __________________________

-------------------DEPARTMENTAL USE BELOW LINE-------------------

FACILITY OCA# 09503139Z REQUEST BY (name) _______________________

FACILITY NAME: Children's Home Society TELEPHONE # ____________
Date 1st Prints Taken: ________ Prints Taken By: ________________
Date Transmitted: ________ Transmit #: ______________________
Date 1st Results Received: ________ Rejected (circle)

Check One:

☐ Foster Screening: Foster Parent / Foster Adult / Foster Sitter (circle one)
☐ Adoption Screening: Adoption Parent / Adopt Adult / Adoption Sitter (circle one)
Please fax to The Foster and Adoptive Parents Association at 352-2544 and call 352-2540 to schedule your fingerprint appointment. A fingerprint check is requested from adult persons who have not been licensed and thoroughly screened by the Department of Children and Families. This is to safeguard that a child is not left in the care of someone who may have criminal charges found in Florida Statute 435.045 or any other charges, which may indicate a potential risk to a child.

LIVE SCAN INFORMATION FORM

NAME: ________________________________
ALIASES: ________________________________
SS#: ________________________________
DOB: ________________________________
PLACE OF BIRTH: ________________________________
COUNTRY OF CITIZENSHIP: ________________________________
HOME ADDRESS: ________________________________

CIRCLE ONE: GENDER - M or F

CIRCLE ONE: RACE - A - ASIAN I - NATIVE AMERICAN
B - BLACK W - CAUCASIAN / LATINO

EYE COLOR: ____________ HEIGHT: ____________
HAIR COLOR: ____________ WEIGHT: ____________
DRIVERS LICENSE #: ________________________________
EMPLOYEE NAME AND ADDRESS ________________________________

-------------------------------------------------DEPARTMENTAL USE BELOW LINE-------------------------------------------------
FACILITY OCA# 09503139Z REQUEST BY (name) ________________________________

FACILITY NAME: Childrens Home Society TELEPHONE # ________________________________

Date 1st Prints Taken: ____________ Prints Taken By: ________________________________
Date Transmitted: ____________ Transmit #: ________________________________
Date 1st Results Received: ____________ Rejected (circle) ________________________________

Check One:

☐ Foster Screening: Foster Parent / Foster Adult / Foster Sitter (circle one)
☐ Adoption Screening: Adoption Parent / Adopt Adult / Adoption Sitter (circle one)
REFERENCE CONTACT INFORMATION

Family Name: ____________________________________________________________

1. Relative -
Name: _________________________________________________________________
Phone #: ______________________________ E-Mails: __________________________
Street: ________________________________________________________________
City/State/Zip: ________________________________________________________

2. Personal -
Name: _________________________________________________________________
Phone #: ______________________________ E-Mails: __________________________
Street: ________________________________________________________________
City/State/Zip: ________________________________________________________

3. Personal -
Name: _________________________________________________________________
Phone #: ______________________________ E-Mails: __________________________
Street: ________________________________________________________________
City/State/Zip: ________________________________________________________

4. Employer (Parent 1)-
Company Name: ____________________________ Name of Supervisor: _________
Phone #: ______________________________ E-Mails: __________________________
Street: ________________________________________________________________
City/State/Zip: ________________________________________________________

5. Employer (Parent 2)- or another personal reference if only one parent
Company Name: ____________________________ Name of Supervisor: _________
Phone #: ______________________________ E-Mails: __________________________
Street: ________________________________________________________________
City/State/Zip: ________________________________________________________
ADOPTIVE APPLICANT PHYSICAL EXAMINATION

To Examining Physician: In evaluating the applicant, this agency must be guided by your medical findings as reported on this form. Please print or type all information. Note "N/A" or "None" if applicable. Thank you for your assistance. Please do not leave any blanks.

Applicant's Name: _______________________________ DOB: ____________

Address: _____________________________________________

1. MEDICAL HISTORY: Has the patient ever had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Year</th>
<th>Outcome</th>
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</table>

Type(s) and date(s)__________

II. PHYSICAL EXAMINATION

Date of Exam: ___________________________ Height: ___________ Weight: ___________ Blood Pressure: ___________
Vision: _______________________________ Hearing: ___________________________
Heart: ______________________________ Liver: ______________________________ Lung: ___________________________
Lymph: ______________________________ Thyroid: ____________________________
Nervous System: _____________________

How long has this person been under your care? ___________________________________________

What is your assessment of the patient's overall health? _______________________________________

Is the patient taking any medications? ________ No ________ Yes ________ If yes, list type of medications taken, dosage and purpose: _________________________________________________

Do you know of any physical or mental conditions that will affect the applicant's ability to parent? ___________

Please explain: __________________________________________

Are you aware of any reason why this patient should not adopt a child? __________________________

Physician's Signature: ___________________________ Date: ____________

M.D. License No: ___________________________ Phone Number: __________________________

Physician's Name (please print clearly): __________________________

Address: ___________________________________________
ADOPTIVE APPLICANT PHYSICAL EXAMINATION

To Examing Physician: In evaluating the applicant, this agency must be guided by your medical findings as reported on this form. Please print or type all information. Note "N/A" or "None" if applicable. Thank you for your assistance. Please do not leave any blanks.

Applicant's Name: ________________________________  DOB: ________

Address: _______________________________________

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II. PHYSICAL EXAMINATION

Date of Exam: ________________  Height: __________  Weight: ______  Blood Pressure: __________

Vision: ____________________  Hearing: __________

Heart: ____________________  Liver: __________  Lung: __________

Lymph: ____________________  Thyroid: __________

Nervous System: ________________

How long has this person been under your care? __________________

What is your assessment of the patient's overall health? ________________

Is the patient taking any medications? _________No _________Yes  If yes, list type of medications taken, dosage and purpose: ____________________

Do you know of any physical or mental conditions that will affect the applicant's ability to parent? ____________________

Please explain: ____________________

Are you aware of any reason why this patient should not adopt a child? ____________________

Physician's Signature: ____________________  Date: ________________

M.D. License No: ________________  Phone Number: ________________

Physician's Name (please print clearly): ____________________

Address: ____________________
HEALTH CERTIFICATE

Applicant's Name: ___________________________ DOB: ______

Address: _______________________________________

The above individual has applied with the Florida Department of Children & Families to be considered as an adoptive parent. The information you provide will help us in considering the applicant through the assessment process. Please feel free to make additional comments.

How long has this person been under your care? __________________________________________

Date of last visit? ___________________________________________________________________

What is the patient's general health and physical condition? _______________________________

_________________________________________________________________________________

Does the individual have any history or evidence of organic or functional disorder? ____________

_________________________________________________________________________________

What is the diagnosis? ________________________________ Prognosis? _______________________

Current medication/dosage/purpose (condition/illness that medications prescribed should be listed under diagnosis)

_________________________________________________________________________________

_________________________________________________________________________________

How would you describe this person's emotional stability? _________________________________

Is this person free from contagious or communicable diseases? _____________________________

Is this person physically and emotionally capable of performing parental responsibilities? ____________

Are you aware of any past or current issues of substance abuse, mental health, physiological or surgical services? ___________

If so, please describe: __________________________________________________________________

Additional comments: __________________________________________________________________

Physician's Signature: ___________________________________ Date: ________________

M.D. License No: ___________________________ Phone Number: _______________________

Physician's Name (please print clearly): ________________________________________________
CHILDREN'S HOME SOCIETY
3333 Forest Hill Blvd., West Palm Beach, FL 33406
Phone: 561-868-4334 * Fax: 561-868-4496

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M.D. License No: ____________________________  Phone Number: ____________________________

Physician's Name (please print clearly): ____________________________
ACKNOWLEDGEMENT OF
FIREARMS SAFETY REQUIREMENTS

Florida Statute 790.174 (Safe storage of firearms required) states:

(1) A person who stores or leaves, on a premise under his or her control, a loaded firearm, as defined in s. 790.001, and who knows or reasonably should know that a minor is likely to gain access to the firearm without the lawful permission of the minor's parent or the person having charge of the minor, or without the supervision required by law, shall keep the firearm in a securely locked box or container or in a location which a reasonable person would believe to be secure or shall secure it with a trigger lock, except when the person is carrying the firearm on his or her body or within such close proximity thereto that he or she can retrieve and use it as easily and quickly as if he or she carried it on his or her body.

(2) It is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, if a person violates subsection (1) by failing to store or leave a firearm in the required manner and as a result thereof a minor gains access to the firearm, without the lawful permission of the minor's parent or the person having charge of the minor, and possesses or exhibits it, without the supervision required by law:
   (a) In a public place; or
   (b) In a rude, careless, angry, or threatening manner in violation of s. 790.10.
This subsection does not apply if the minor obtains the firearm as a result of an unlawful entry by any person.

(3) As used in this act, the term "minor" means any person under the age of 16.

I/We, ____________________________,
acknowledge that I/we have read and understand this document.

__________________________
Date

__________________________
Caregiver/Adoptive Parent Signature

__________________________
Caregiver/Adoptive Parent Signature

NOTE: This acknowledgement must be executed by all foster and adoptive parents during the home study process.
Please provide the name and address of any and all children of the prospective adoptive parents who DO NOT reside in the home.

1. Name: ___________________________ Date of Birth: ______
   Address: ____________________________________________
   Phone Number: ______________________________________

2. Name: ___________________________ Date of Birth: ______
   Address: ____________________________________________
   Phone Number: ______________________________________

3. Name: ___________________________ Date of Birth: ______
   Address: ____________________________________________
   Phone Number: ______________________________________

4. Name: ___________________________ Date of Birth: ______
   Address: ____________________________________________
   Phone Number: ______________________________________

5. Name: ___________________________ Date of Birth: ______
   Address: ____________________________________________
   Phone Number: ______________________________________