



**Rockingham County Department of Social Services**  
Post Office Box 61  
Wentworth, North Carolina 27375  
(336) 342-1394

## Foster Parent Application

We understand this application in no way obligates you or the Rockingham County Department of Health & Human Services, but is a statement of intention and can be withdrawn by either party at any time. **Please complete the entire application.** Do not leave any fields blank, use N/A if not applicable.

How were you referred to us?	
<input type="checkbox"/> Information Session	<input type="checkbox"/> On-Line <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Community Event
<input type="checkbox"/> Other:	<input type="checkbox"/> Referred by a Foster-Adopt Parent (name)

## GENERAL INFORMATION

Name\_\_\_\_\_

Legal Last Name

Legal First Name

Legal Middle Name

Name\_\_\_\_\_

Legal Last Name

Legal First Name

Legal Middle Name

Address\_\_\_\_\_

Street

City

Zip Code

Home Telephone:\_\_\_\_\_ Mobile Phone:\_\_\_\_\_

Email Address(es)\_\_\_\_\_

Rockingham County Resident? YES ☐ NO ☐ Length of residence in Rockingham County\_\_\_\_\_

Please list other counties in NC where you have lived:\_\_\_\_\_

\_\_\_\_\_

Please list other cities and states where you have lived:\_\_\_\_\_

\_\_\_\_\_

## HOUSEHOLD COMPOSITION

<b><u>Prospective Foster Parent 1</u></b>	<b><u>Prospective Foster Parent 2</u></b>
Name _____	Name _____
Date of Birth _____	Date of Birth _____
Place of Birth _____	Place of Birth _____
Valid Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No (please explain why if you do not have a valid license)	Valid Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No (please explain why if you do not have a valid license)
Do you own a car? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you own a car? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a High School diploma or GED? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a High School diploma or GED? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of years you completed in college _____	Number of years you completed in college _____

Marital Status: ☐ Single      ☐ Married      ☐ Divorced      ☐ Widowed      ☐ Separated

Marriage Date: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

<b><u>Prospective Foster Parent 1</u></b>	<b><u>Prospective Foster Parent 2</u></b>
<u>Date of Previous Marriage(s):</u> _____, _____, _____	<u>Date of Previous Marriage(s):</u> _____, _____, _____
Name of Previous Spouse(s): _____, _____, _____	Name of Previous Spouse(s): _____, _____, _____
How was marriage terminated? _____	How was marriage terminated? _____
Date of termination:	Date of termination:
Place of termination:	Place of termination:

**Children In Home (Please provide full names)**

<b>Name</b>	<b>Date of Birth</b>	<b>School Grade or Occupation</b>

**Children Out of Home (Please provide full names)**

<b>Name</b>	<b>Date of Birth</b>	<b>Occupation</b>	<b>Address</b>

**Other Members of Household (Please provide full names)**

<b>Name</b>	<b>Date of Birth</b>	<b>Occupation</b>	<b>Address</b>

**\*All adults in home must complete MAPP Training and Background Checks\***

Do you live in a:     ☐ House     ☐ Apartment     ☐ Mobile Home     ☐ Condo/Townhouse

Do you:     ☐ Own     ☐ Rent     Monthly Payment \_\_\_\_\_

Property Management Company or Owner's Name \_\_\_\_\_

Number of Rooms \_\_\_\_\_ Number of Bedrooms \_\_\_\_\_

Describe Present Sleeping Arrangements:

Bedroom 1

\_\_\_\_\_

Bedroom 2

\_\_\_\_\_

Bedroom 3

\_\_\_\_\_

Bedroom 4

\_\_\_\_\_

In which bedroom would foster/adoptive child(ren) sleep?    1       2       3       4

Is there a body of water on or near your property?   ☐ Yes    ☐ No

## **FAMILY INFORMATION**

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Address : \_\_\_\_\_

Phone \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Has either prospective parent had any serious illness, operation, mental health condition or chronic physical condition? If yes, please explain below:

\_\_\_\_\_

\_\_\_\_\_

School(s) child(ren) will attend:

Elementary                      \_\_\_\_\_

Middle                              \_\_\_\_\_

High School                      \_\_\_\_\_

Do you home school    ☐ Yes    ☐ No

Religious Affiliation: (if any) \_\_\_\_\_

Church Name and Address: \_\_\_\_\_

Do you have social media accounts? If so, please provide your profile name:

Facebook: \_\_\_\_\_

Twitter: \_\_\_\_\_

Instagram: \_\_\_\_\_

Other: \_\_\_\_\_

### **FAMILY INCOME**

<b>Prospective Foster Parent 1</b>	<b>Prospective Foster Parent 2</b>
Occupation:	Occupation:
Employer:	Employer:
Address:	Address:
Length of Employment:	Length of Employment:
Business Phone:	Business Phone:
Work Hours: Monday Tuesday Wednesday Thursday Friday Saturday Sunday	Work Hours: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Additional Income Source(s):  Annual Amount:	Additional Income Source(s):  Annual Amount:

### **Combined Family Income:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Under 10,000    | <input type="checkbox"/> 10,001 - 20,000  | <input type="checkbox"/> 20,001 - 30,000 | <input type="checkbox"/> 30,001 - 40,000 |
| <input type="checkbox"/> 40,001 - 50,000 | <input type="checkbox"/> 50,001 - 60,000  | <input type="checkbox"/> 60,001 - 70,000 | <input type="checkbox"/> 70,001 - 80,000 |
| <input type="checkbox"/> 80,001 - 90,000 | <input type="checkbox"/> 90,001 - 100,000 | <input type="checkbox"/> 100,000 +       |  |

## REFERENCES/ADDITIONAL INFORMATION

Each applicant should each list three references who have known you will for the last three to five years. Please use referrals that are aware of your desire to foster or adopt.

	Name	Address	Phone	Email
<b>Applicant I</b>				
<b>Applicant II</b>				

Do you have a daycare or provide childcare for a child or children on a regular basis in your home?

☐ Yes ☐ No If yes, please provide the name \_\_\_\_\_

Do you have pets in your home? ☐ Yes ☐ No

If yes, how many? \_\_\_\_\_

Size (check all that apply): ☐ Small ☐ Medium ☐ Large

Breed(s): \_\_\_\_\_

Veterinarian: \_\_\_\_\_

Are you or anyone in your household related to an employee of the Rockingham County Department of Health and Human Services? Yes No

If yes, to whom are you related and how are you related?

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## QUESTIONS CONCERNING CARE OF A CHILD

Explain why you are interested in being a foster parent.

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Do you know any foster/adoptive parents of foster children ☐ Yes ☐ No

Would you accept a child with a learning disability? ☐ Yes ☐ No

Would you accept a child with a physical challenge? ☐ Yes ☐ No

Would you accept a child who is mentally challenged? ☐ Yes ☐ No

Would you accept a child who has emotional problems? ☐ Yes ☐ No

How would you discipline a foster child who misbehaves?

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Have you ever been charged with or found guilty of child abuse or neglect? ☐ Yes ☐ No

Have you ever been charged with or found guilty of a felony? ☐ Yes ☐ No

Have you ever been charged with or found guilty of a misdemeanor? ☐ Yes ☐ No

Have you ever been charged with or found guilty of a traffic violation? ☐ Yes ☐ No

Have you ever been charged incarcerated? ☐ Yes ☐ No

Have you ever been in a local jail, state prison or federal penitentiary? ☐ Yes ☐ No

Have you ever been incarcerated abroad? ☐ Yes ☐ No

Has anyone in your home ever been charged with or found guilty of child abuse or neglect?  
☐ Yes ☐ No

Are you now receiving or have you ever-received psychiatric treatment or been hospitalized for emotional or mental illness or depression? ☐ Yes ☐ No (Checking yes will not disqualify you as a prospective foster parent)

If yes, please explain\_\_\_\_\_

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Do you smoke? ☐ Yes ☐ No

Are you currently dating someone, or have a significant other? ☐ Yes ☐ No

Are you interested in Fostering? ☐ Yes ☐ No

Are you open to Adoption? ☐ Yes ☐ No

I/We wish to be considered for \_\_\_\_\_ number of children.

Gender: ☐ Male ☐ Female ☐ Either

Age Range: ☐ 0- 5 ☐ 6-12 ☐ 13-21 ☐ Any age  
(check all that apply)

Have you ever applied to foster or adopt a child for any other agency? ☐ Yes ☐ No

If yes, when: \_\_\_\_\_

What agency? \_\_\_\_\_

Status of Application: \_\_\_\_\_

Have you ever been licensed by another agency? ☐ Yes ☐ No

If yes, name of agency: \_\_\_\_\_

Date(s) licensed: \_\_\_\_\_

Have you ever applied to foster at Rockingham County DHHS? \_\_\_\_\_

Have you ever been licensed at Rockingham County DHHS? ☐ Yes ☐ No

I /We understand that in making this application there is no final commitment on either side.

\_\_\_\_\_  
Signature of Prospective Foster Parent 1

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Prospective Foster Parent 2

\_\_\_\_\_  
Date

By signing this application, you confirm to the best of your knowledge, the information given is true and accurate.



For County Office Use Only

☐ Foster Care

☐ Foster/Adopt ☐ Relative

## CAN I PARENT THIS CHILD?

Are you currently parenting a child in Rockingham County custody?

☐ Yes ☐ No

If yes, who \_\_\_\_\_

Name of Social Worker(s)? \_\_\_\_\_

Are you applying to become a foster parent to foster a relative child?

☐ Yes ☐ No

If yes, who \_\_\_\_\_

What state and county do they live in? \_\_\_\_\_

Name of Social Worker(s)? \_\_\_\_\_

I am interested in a ☐ boy ☐ girl ☐ either ☐ siblings, no younger than \_\_\_\_ and no older than \_\_\_\_.

I am interested in:	Yes	No	Uncertain
Child/Children who are still visiting biological parents			
Child/Children too young for daycare			
Child/Children needing ongoing therapy after placement			
Child/Children who need continuing ties with biological family members			
A sibling group (two or more children in the same family)			
Teenagers 12-18			
Child/children with parents or relatives with inheritable diseases (or traits), mental illness or are mentally retarded			
Child/Children whose biological family has social problems (addictions, incest, etc.)			
Child/Children with an alternative lifestyle			

# CAN I PARENT THIS CHILD?

**Special Needs Check List -----Please check all that you are willing to consider**

<p><b>Emotional Needs</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Adjustment Disorder</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Attachment Disorder</p> <p><input type="checkbox"/> Behavior Problems</p> <p><input type="checkbox"/> Bi-Polar</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Conduct Disorder</p> <p><input type="checkbox"/> Cruelty to Animals</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Developmental Disabilities</p> <p><input type="checkbox"/> Dysthymia</p> <p><input type="checkbox"/> Emotional Problems</p> <p><input type="checkbox"/> Fire Starter</p> <p><input type="checkbox"/> Loss Issues</p> <p><input type="checkbox"/> Lying</p> <p><input type="checkbox"/> Obsessive Compulsive Disorder</p> <p><input type="checkbox"/> Oppositional Defiant Disorder</p> <p><input type="checkbox"/> Physically Aggressive</p> <p><input type="checkbox"/> Post-Traumatic Stress Disorder</p> <p><input type="checkbox"/> Property Destruction</p> <p><input type="checkbox"/> Psychosis</p> <p><input type="checkbox"/> Reactive Attachment Disorder</p> <p><input type="checkbox"/> Run Away</p> <p><input type="checkbox"/> Self-Abusive</p> <p><input type="checkbox"/> Sexually Acting Out</p> <p><input type="checkbox"/> Steals</p> <p><input type="checkbox"/> Takes psychiatric medication</p> <p><input type="checkbox"/> Verbal Threats</p> <p><b>Learning Needs</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Learning Disability</p> <p><input type="checkbox"/> Aphasia</p> <p><input type="checkbox"/> Attention Deficit Disorder</p> <p><input type="checkbox"/> Attention Deficit Hyperactivity Disorder</p> <p><input type="checkbox"/> Central auditory processing disorder</p> <p><input type="checkbox"/> Developmental articulation disorder</p> <p><input type="checkbox"/> Dyslexia</p> <p><input type="checkbox"/> Expressive language disorder</p> <p><input type="checkbox"/> Motor skills disorder</p> <p><input type="checkbox"/> Non-specific learning disorder</p> <p><input type="checkbox"/> Receptive language disability</p>	<p><b>Mental Retardation</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Down Syndrome</p> <p><input type="checkbox"/> Lead Poisoning</p> <p><input type="checkbox"/> Microcephalus</p> <p><input type="checkbox"/> MR - not specified</p> <p><input type="checkbox"/> MR - genetic</p> <p><input type="checkbox"/> Phenylketonuria (PKU)</p> <p><input type="checkbox"/> Prader Willie Syndrome</p> <p><input type="checkbox"/> Trisomy 13</p> <p><input type="checkbox"/> Trisomy 18</p> <p><input type="checkbox"/> William Syndrome</p> <p><b>Risk Factors</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Alcohol exposed</p> <p><input type="checkbox"/> Drug exposed</p> <p><input type="checkbox"/> HIV exposed</p> <p><input type="checkbox"/> Lead Poisoning</p> <p><input type="checkbox"/> Mental Illness in birth family</p> <p><input type="checkbox"/> Mental Retardation in birth family</p> <p><input type="checkbox"/> Neglected</p> <p><input type="checkbox"/> Physically Abused</p> <p><input type="checkbox"/> Premature Birth</p> <p><input type="checkbox"/> Schizophrenia in birth family</p> <p><input type="checkbox"/> Sexually Abused</p> <p><b>Physical Needs</b></p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> AIDS/HIV</p> <p><input type="checkbox"/> Autism</p> <p><input type="checkbox"/> Blindness/Visual Impairment</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cerebral Palsy</p> <p><input type="checkbox"/> Congenital Heart Disease</p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> Deaf/Profound hearing loss</p> <p><input type="checkbox"/> Developmental Disabilities</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Encopresis</p> <p><input type="checkbox"/> Enuresis</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Failure to thrive</p> <p><input type="checkbox"/> Fetal Alcohol Syndrome</p>	<p><b>Physical Needs cont.</b></p> <p><input type="checkbox"/> HIV positive</p> <p><input type="checkbox"/> Hearing loss -partial</p> <p><input type="checkbox"/> Heart defect</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Hydrocephalus</p> <p><input type="checkbox"/> Hyperactivity</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Macrocephalic</p> <p><input type="checkbox"/> Medically Fragile</p> <p><input type="checkbox"/> Microcephalus</p> <p><input type="checkbox"/> Missing Limbs</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Muscular Dystrophy</p> <p><input type="checkbox"/> Non-Ambulatory</p> <p><input type="checkbox"/> Non-Verbal</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Partially Verbal</p> <p><input type="checkbox"/> Pica</p> <p><input type="checkbox"/> Quadriplegia</p> <p><input type="checkbox"/> Sexual Transmitted Disease</p> <p><input type="checkbox"/> Scoliosis</p> <p><input type="checkbox"/> Seizure Disorder</p> <p><input type="checkbox"/> Sickle Cell Anemia</p> <p><input type="checkbox"/> Sickle Cell Trait</p> <p><input type="checkbox"/> Speech Disorder</p> <p><input type="checkbox"/> Spina Bifida</p> <p><input type="checkbox"/> Terminal Illness</p> <p><input type="checkbox"/> Total Care</p> <p><input type="checkbox"/> Tourette Syndrome</p> <p><input type="checkbox"/> Trach Syndrome</p> <p><input type="checkbox"/> Tube Feeding</p>
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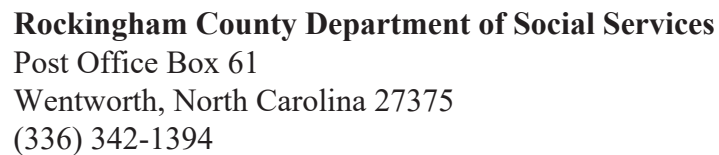
## **FOSTER HOME LICENSING & ADOPTION REQUIREMENTS**

1. **AGE:** Applicants must be at least 23 years old to be considered for foster home licensure and adoptive homes.
2. **MARITAL STATUS:** Single, married, widowed, separated and divorced persons may be eligible for licensure. Couples must be married at least 1 year prior to licensing. It is suggested that couples be married at least 3 years prior to adopting. Relationships must be stable for 1 year prior to applying.
3. **INCOME:** Applicants must meet the minimum income scale requirements. Income cannot be below poverty level and placing a child in the home cannot put your income below the poverty level or put an extensive financial strain on the family.
4. **HOUSING:**
  - A. **Fire Inspection Requirements**  
Fire extinguishers (5lbs. minimum content, ABC type), smoke detectors on each living level, a posted evacuation plan on each floor, a telephone, etc.
  - B. **Health Inspection Requirements**  
Applicants are responsible for providing a safe drinking water supply
  - C. Children placed in foster care must be provided their own bed space and space for belongings.
5. **EDUCATION:** Must have a High School Diploma or GED
6. **MEDICAL EXAMS:** Physicals are required for initial licensure of everyone in the household. In addition to physicals, all adults must have a TB test during the initial licensure at the discretion of their **physician**. If the initial TB test results are negative, applicants are not required to repeat the TB test for re-licensure. Children under age 18 are not required to take a TB test.
7. **CRIMINAL RECORD CHECKS WITH FINGERPRINTING:** Signed permission forms are required each year in order that annual clearance checks may be done through the local sheriff, police, and clerk of court offices. Fingerprinting is done upon initial clearance only.
8. **REFERENCES:** Reference checks will be completed by your Family Recruitment Social Worker. Full names and addresses (including zip code) need to be stated on your application. School references are also requested when appropriate.
9. **TRAINING:** “Model Approach to Partnership in Parenting” (MAPP), a 30-hour training course designed by the Child Welfare Institute on contract with North Carolina State Department of Human Resources is required for licensing. An additional twenty hours of training is required bi-annually for re-licensing.
10. **FAMILY ASSESSMENT:** Three to four consultations with the family in addition to class time are necessary. Ongoing contacts are made after licensing is approved with a minimum of quarterly face to face contacts by a Family Recruitment social worker are required.
11. **FOSTER PARENT AGREEMENT:** An agreement made between DHHS and foster parents stating what DHHS and foster parents will do regarding working together to provide the best services/care for children in foster care/DHHS custody. **Each applicant must agree not to use physical punishment on children in DHHS custody who are placed in the home.**
12. **TRANSPORTATION:** Must have reliable transportation and insurance as well as willing to transport child(ren) to appointments and events. Vehicles used to transport foster children must be maintained in safe operating conditions at all times, and inspected and registered according to federal, state, and local laws. You must have a valid NC Drivers License. You cannot transport children unless you have a valid NC Drivers License.

**Note:** Consideration for persons who have been substantiated for charges of abuse or neglect will **NOT** be at the county’s discretion. Felonious criminal charges and extensive criminal activities can possibly preclude foster care licensure or approval for adoption. Each individual situation will be assessed on a case-by-case basis.

## **PERMISSIBLE DENIAL OF APPLICATIONS DURING PRE-SERVICE TRAINING OR APPLICATION REVIEW**

- Clear and documented criminal history: Felony convictions, assault convictions and central registry substantiations
- Income: Applicant families need to meet the minimum income scale requirements and have adequate income to financially support their own family.
- Applicant is underage: Applicant must be at least 23 years old for foster care
- Homelessness: The applicant is unable to provide a home address or is currently residing in a shelter or some other form of temporary housing such as the YMCA or hotel/ motel.
- No room for children: The applicant is not child specific or an interested individual and does not have adequate space for a child(ren) given their current living arrangement. If the applicant states that she/he is “moving”, accept the application if the applicant can identify a new address and firm date for the move. Return the application if there is no firm plan. The applicant can continue in the training.
- Incomplete or false application: All information must be true to the best of applicant’s knowledge. If information is missing applicant must complete and resubmit. If false information is submitted, application is subject to denial or termination.
- Applicant is not interested in the types of children served by the county.
- Only one applicant of a couple: If only one half of an applicant couple is in attendance and the other half is refusing to attend or participate.
- Applicant has legal custody of child they wish to foster or adopt: Once a child is placed in the legal custody of a family, the family cannot become a foster home for the child. The family may however, become foster/adoptive parents for other children.
- Landlord refuses to sign approval form: The agency will not be able to complete the required safety and fire inspections for the home study.
- If and applicant is believed to be intoxicated, suffering from mental illness, violent, aggressive or any other suspicious behavior, Supervisor will determine eligibility.
- Pet Policy: Pets will be assessed on a case by case basis. Supervision is expected of all foster children around animals. Foster children cannot be primarily responsible for the care of the animals. Some concerns that can possibly preclude foster care licensure or approval for adoption are: vicious/aggressive breeds of dogs; excessive number of pets, odor, not having medical records for your animals. The agency has the right to request a temperament test from a veterinarian that speaks to how the animal responds to strangers. The test would be at the prospective family’s expense.
- Smoking: Because of the dangers of secondary smoke inhalation, we require foster parents who smoke to refrain from smoking in enclosed area around the children. All matches and lighters must be stored away from children, and you are responsible for ensuring that children do not have access to them.
- Unmarried Couples: If you are not married, but are living as a couple, your relationship must demonstrate stability, and both partners must attend MAPP.
- Applicants must have a valid North Carolina drivers license.



(Record to be checked) PLEASE PRINT

APPLICANT SIGNATURE: \_\_\_\_\_

**Staff Requesting Record Check:**\_\_\_\_\_



## RELEASE OF INFORMATION

I \_\_\_\_\_ hereby give my permission for Rockingham County Department of Health & Human Services to request information from the Rockingham County Clerk of Superior Court, NC Department of Corrections Offender Information, NC Responsible Individuals List, NC Sex Offender Public Protection Registry, Nurse Aide I and Health Care Personnel Registry concerning criminal records, if any, in connection with my application/re-license for (foster home licensing and/or adoption). I further agree to the release of said information by the Rockingham County Clerk of Superior Court, & others listed above to the Rockingham County Department of Health & Human Services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant 1 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant 2 Signature



## REQUEST FOR CRIMINAL RECORD CHECK

(Record to be checked) PLEASE PRINT

NAME: \_\_\_\_\_  
(Last) (First) (Middle)  
\_\_\_\_\_  
(Maiden)

BIRTHDATE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE: \_\_\_\_\_ SSN: \_\_\_\_\_

PRESENT ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DRIVER'S LICENSE#: \_\_\_\_\_ STATE: \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_

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CRIMINAL RECORD:	See Attached	No Match
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CLEAR:	See Attached	No Match
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PAROLE/PROBATION:	See Attached	No Match
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[www.doc.state.nc.us/offenders](http://www.doc.state.nc.us/offenders)

SEX OFFENDER REGISTRY:	See Attached	No Match
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[www.ncfindoffender.com](http://www.ncfindoffender.com)

NURSE I AIDE & HEALTH REGISTRY:	See Attached	No Match
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[www.ncnar.org/faq.html](http://www.ncnar.org/faq.html)

STAFF COMPLETING RECORD CHECK: \_\_\_\_\_ DATE: \_\_\_\_\_

Staff requesting Record Check: \_\_\_\_\_



## RELEASE OF INFORMATION

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\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant 1 Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant 2 Signature



## FINANCIAL STATEMENT

**Applicant 1 Name:** \_\_\_\_\_

Employer \_\_\_\_\_

What is your Net **monthly** income \$ \_\_\_\_\_

Additional Sources of Income from: \_\_\_\_\_

**Monthly** Amount: \$ \_\_\_\_\_

**Applicant 2 Name:** \_\_\_\_\_

Employer \_\_\_\_\_

What is your Net **monthly** income \$ \_\_\_\_\_

Additional Sources of Income from: \_\_\_\_\_

**Monthly** Amount: \$ \_\_\_\_\_

### Please provide the current year's Tax Form Verification

#### Assets

Do you have a regular savings plan? If so, please explain: \_\_\_\_\_

Life Insurance: Applicant 1: \$ \_\_\_\_\_ Applicant 2: \$ \_\_\_\_\_

Medical coverage for family: \_\_\_\_\_

Mortgage Insurance: ☐ Yes ☐ No

Other Assets: \_\_\_\_\_

Approximate value of real estate and personal: \$ \_\_\_\_\_

Property tax value: \$ \_\_\_\_\_

#### Outstanding Debt:

Balance Due

Home \$ \_\_\_\_\_ Personal Loans \$ \_\_\_\_\_

Other Property \$ \_\_\_\_\_ Taxes \$ \_\_\_\_\_

Cars and Vehicles \$ \_\_\_\_\_ Medical \$ \_\_\_\_\_

Furnishings/Appliances \$ \_\_\_\_\_ Credit Cards \$ \_\_\_\_\_

College Loans \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Have you ever filed Bankruptcy? \_\_\_\_\_ Year: \_\_\_\_\_ Explain: \_\_\_\_\_

Have you ever had a foreclosure? \_\_\_\_\_ Year: \_\_\_\_\_ Explain: \_\_\_\_\_

#### Use of Income

*Please estimate your monthly average expenditures: (you may be asked to provide proof)*

Mortgage/Rent \$ \_\_\_\_\_ Installment Payments \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_ Savings & Investments \$ \_\_\_\_\_

Food \$ \_\_\_\_\_ Charitable Contributions \$ \_\_\_\_\_

Cars and Vehicles \$ \_\_\_\_\_ Recreation & Vacation \$ \_\_\_\_\_

Household Furnish/Appliances \$ \_\_\_\_\_ Child Care \$ \_\_\_\_\_

Transportation gas & maintenance \$ \_\_\_\_\_ Medical & Dental \$ \_\_\_\_\_

Clothing \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

SIGNATURES:

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Applicant 1

\_\_\_\_\_  
Applicant 2

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