MORRISON COUNTY

Health and Human Services
Nathan Bertram
Director
Government Center
213 S.E. 1st Avenue
Little Falls, Minnesota 56345-3196
320-632-7800
Toll Free: 1-800-269-1464
Fax: 320-632-0225
Email:nateb@co.morrison.mn.us

Dear Child Foster Care Provider:

It is time to relicense your Child Foster Care Home. Please complete the forms within this packet prior to the relicensing visit. We need to receive them as soon as possible in order to have them to DHS prior to your license expiration date.

Annual Training Requirements:
12 credit hours of training are required annually for each licensed provider

- Child Passenger Restraint Training (Required every 5 years if caring for children under 8, must provide proof of attendance)
- Children's Metal Health Training (2 hours required initially, 1 hour annually)
- Fetal Alcohol Spectrum Disorder (1 hour required annually)
- Child Mandated Reporter Training (1 hour required annually)
- Sudden Unexpected Infant Death (Required every 5 years if caring for children under 5 years)
- Abusive Head Trauma (Required every 5 years if caring for children under 5 years)

Please note: It would speed things up significantly for you to have your fire extinguishers reserviced, your smoke detectors checked, and well water tested prior to my visit.

- **PLEASE RETURN EVERYTHING EXCEPT THE HOME SAFETY CHECKLIST.**
  The completed packet can be dropped in the agency drop box, brought into our Agency or mailed to:
  Morrison County Health and Human Services
  Child Foster Care Licensing
  213 SE 1st Ave
  Little Falls, MN 56345

Thank you for your cooperation. Should you have any questions, please contact us at:

Nikki Alich: 320.631.0402
Kim DeZurik: 320.632.0278

Sincerely,

Your Morrison County Child Foster Care Licensors

DEPARTMENT OF HUMAN SERVICES

DHS-4258A-ENG 9-22

Minnesota Adoption and Child Foster Care Application

Instructions

To apply for a child foster care license and/or adoption home study, complete and send this form along with the Minnesota Adoption and Foster Care Individual Fact Sheet (DHS-4258B) for each applicant to your local county social service agency or a private child-placing agency.

LICENSING AGENCY	
TYPE OF APPLICATION ◯ New application ◯ Update ◯ Renewal ◯ Change of premises	
APPLYING FOR ☐ Foster care/adoption ☐ International or Domestic Infant Adoption	
TYPE OF CHILD YOU ARE INTERESTED IN ◯ Male ◯ Female ◯ Either Age range _____ ☐ Sibling group of up to _____ children ☐ Specific child _____	**FOR INTERNATIONAL ADOPTION ONLY** INDICATE SPECIFIC COUNTRY OR AREA REQUESTED

Applicant 1

Share about yourself and where you live.

LAST NAME	FIRST NAME	MIDDLE NAME	FORMER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS
		◯ Married ◯ Divorced ◯ Separated ◯ Single

RACE	ETHNICITY
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ White	Hispanic ◯ Yes ◯ No

CURRENT HOME (STREET) ADDRESS (P.O. BOX if required for mail delivery)	APT. NUMBER

CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

TRIBAL AFFILIATION	LANGUAGES SPOKEN	RELIGION	EDUCATION

AREAS OF SPECIALIZED EDUCATION	OCCUPATION	NUMBER OF HOURS IN WORK WEEK	TYPICAL WORK SCHEDULE

Have you lived at any other address in the past five years? ◯ No ◯ Yes If yes, complete below

Address 1			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Is there a second applicant in the home? ◯ No ◯ Yes If yes, complete the information below

Applicant 2

LAST NAME	FIRST NAME	MIDDLE NAME	FORMER NAMES

SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS
		◯ Married ◯ Divorced ◯ Separated ◯ Single

RACE	ETHNICITY
☐ Asian ☐ American Indian/Alaska Native ☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ White	Hispanic ◯ Yes ◯ No

CURRENT HOME (STREET) ADDRESS (P.O. BOX if required for mail delivery)	APT. NUMBER

CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS

TRIBAL AFFILIATION	LANGUAGES SPOKEN	RELIGION	EDUCATION

AREAS OF SPECIALIZED EDUCATION	OCCUPATION	NUMBER OF HOURS IN A WORK WEEK	TYPICAL WORK SCHEDULE

Has this applicant lived at any other address in the past five years? ◯ No ◯ Yes If yes, complete below

Address 1			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Emergency evacuation plan

Emergency contact person: Name a person who does not live in your household and would know how to contact you in case of emergency and/or evacuation.

NAME	PHONE

If an emergency evacuation of a home is necessary due to disaster, indicate the specific location where foster children would go (e.g. name of local hotel, address of emergency contact person or foster child's relative):

Do you have additional household members living in the home? ◯ No ◯ Yes

If yes, list all adults and children (not including foster children) living in the home below.

Household member 1			
LAST NAME	FIRST NAME	MIDDLE NAME	
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	
Household member 2			
LAST NAME	FIRST NAME	MIDDLE NAME	
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	

Household member 3			
LAST NAME	FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	
Household member 4			
LAST NAME	FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	
Household member 5			
LAST NAME	FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD	

If you have more household members to report, please attach an additional piece of paper.

Home (Description of home as it pertains to foster care of children)

SCHOOL DISTRICT IN WHICH HOME IS LOCATED	
Children placed in the home would attend the following schools	
ELEMENTARY	MIDDLE/JUNIOR HIGH
HIGH SCHOOL	SCHOOL TRANSPORTATION ☐ Bus ☐ Other _____
DOES APPLICANT HOME SCHOOL? ◯ No ◯ Yes – has applicant's home school plan been approved by the public school district? ◯ Yes ◯ No	
Does anyone smoke in the home? ◯ No ◯ Yes – fill in below	
WHO SMOKES IN THE HOME?	
WHAT IS YOUR PLAN TO PROVIDE A SMOKE-FREE ENVIRONMENT IN YOUR HOME, GARAGE, SURROUNDING AREA, AND CAR?	
Are there pets in the home? ◯ No ◯ Yes - fill in below	
WHAT TYPE(S) OF PETS?	
DO ANY PETS IN THE HOME POSE SAFETY CONCERNS? ◯ Yes ◯ No	DO PETS HAVE CURRENT VACCINATIONS? ◯ Yes ◯ No

Dwelling information (check all that apply)			
☐ Own ☐ Rent	☐ Mobile home ☐ Basement	☐ Single family house ☐ Multi-unit (apartment)	☐ Free standing solid fuel heating appliance

Sleeping arrangements (indicate where foster child will sleep)			
Bedroom floor/level	**Occupants**	**Type of bed/s** Crib, single, double, bunk (if bunk, indicate upper –U or lower –L)	**Storage space for personal possessions**
1.			
2.			
3.			
4.			
LIST AREAS AND/OR ITEMS IN YOUR HOME THAT ARE LOCKED AND/OR INACCESSIBLE TO FOSTER OR ADOPTED CHILD			

Experience with foster care and/or adoption, or any other licensing (including child care, adult foster care, etc.)

Have you ever applied, or worked with another foster care agency? ◯ No ◯ Yes – list all agencies (Minnesota and out-of-state)

Agency name	Address	Dates of involvement and outcomes

Are you currently or have you ever been licensed? ◯ No ◯ Yes – list all agencies (Minnesota and out-of-state)

TYPE OF LICENSE (check all that apply)		
☐ Family child care ☐ Child foster care ☐ Adult foster/community residential setting ☐ Family adult day services ☐ 245D-HCBS ☐ Other		
LICENSE NUMBER (if known)	COUNTY/AGENCY/STATE	EFFECTIVE DATES OF LICENSE (if known)

Have you ever had a Minnesota Department of Human Services (department) license denied or revoked, or the subject of an unfavorable home study?

◯ No ◯ Yes

EXPLAIN (include license type, denial or revocation, who completed the home study, etc.)

Do you operate a business from your residence? ◯ No ◯ Yes

TYPE OF BUSINESS
DESCRIBE IMPACT HOME BUSINESS MAY HAVE ON YOUR FOSTER/ADOPTION PLAN

Substitute caregivers

Whom do you plan to use as a substitute caregiver for foster children or prospective adoptive children (e.g., personal care attendant, nurse, babysitter/respite care)?

NAME			
AGE	PHONE AND/OR EMAIL ADDRESS		
STREET ADDRESS	CITY	STATE	ZIP CODE
RELATIONSHIP TO CHILD (if any)			

Transportation

Do you have a valid driver's license? ◯ No ◯ Yes

Do you own vehicles? ◯ No ◯ Yes

Are there age appropriate car seats? ◯ No ◯ Yes ◯ Will obtain ◯ Not applicable

Do you have adequate insurance for all vehicles? ◯ No ◯ Yes

Do you have access to public transportation? ◯ No ◯ Yes

DISTANCE TO NEAREST PICK-UP LOCATION

DESCRIBE ALTERNATIVE TRANSPORTATION PLAN IF FAMILY NOT HAVE AN OPERATING VEHICLE OR THE HOME IS NOT NEAR PUBLIC TRANSPORTATION

Are you able to transport children to appointments or school when needed? ◯ Yes ◯ No

WHAT ALTERNATIVE TRANSPORTATION ARE YOU ABLE TO PROVIDE?

References (required at initial application only)

Reference 1			
LAST NAME	FIRST NAME	MIDDLE NAME	
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS			PHONE

Reference 2				
LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS	CITY	STATE	ZIP CODE	
EMAIL ADDRESS			PHONE	

Reference 3				
LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS	CITY	STATE	ZIP CODE	
EMAIL ADDRESS			PHONE	

Municipality (Required at initial licensure only)

Applicants for a non-relative residential program license issued by the Minnesota Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to inquire about local ordinance requirements. The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE

Child foster care applicants only

Applicant acknowledgment of public funding reimbursement for licensed services:

Department license holders who receive public funding reimbursement for services provided for care of children in a licensed program must acknowledge they will comply with funding requirements, that compliance with requirements may be monitored by the department's Licensing Division, and they know the consequences for not complying with requirements [Minnesota Statutes, section 245A.04, subd. 1 (h)].

☐ ***As a foster care provider of a child, I acknowledge that I will receive public funding reimbursement for licensed services provided in my program and will comply with all requirements.***

Notice about variances

All foster care licensing agencies are required to provide applicants with a summary of child foster care license requirements and standards. A variance to these requirements and standards may be requested in circumstances that do not jeopardize the health or safety of a child. County and child-placing agencies have authority to issue most variances. Only the department has authority to grant variances for dual licensure, child foster care maximum age requirements, chemical use problems, and variances regarding individuals disqualified for child foster care licensure based on background study information.

By signing below:

I acknowledge that I received the Applicant Privacy Notice: Child Foster Care and/or the Notice of Privacy Practices (DHS-3979). I also acknowledge that information I have provided on this application is complete and true. I agree that:

- I will comply with requirements in Minnesota Statutes, chapter 245A, and all applicable laws and rules, at all times during terms of the license.
- The department's commissioner representative has the right to request any documentation required by Minnesota rules or laws and to inspect my home and its grounds at any time. The documentation and inspection required by rules are necessary for the commissioner to determine whether I am complying with Minnesota rules and laws.
- Any documentation I provide or representations that I make to the commissioner's representative during the application process, during the time I am licensed, during an investigation or throughout the adoption process, will be complete and true. I understand that any misrepresentations or other violations of Minnesota rules and laws may result in immediate suspension, revocation or denial of a child foster care license, denial of an adoption home study, or termination of adoption services.

APPLICANT 1 SIGNATURE	DATE
APPLICANT 2 SIGNATURE	DATE

Authorized agent information (Required only for new applicants)

If more than one applicant, you must designate one applicant to act as the authorized agent authorized to accept service on behalf of all individual license holders of the program. Service on the authorized agent is on all license holders of the program. It is the responsibility of authorized agent to distribute mail received from the department within the facility as needed, and a response provided within stated timelines, when required.

Who is the authorized agent for your child foster care program?

NAME	EMAIL ADDRESS

Applicant Privacy Notice: Child foster care

To apply for a license, you must provide identifying information, some of which is public, unless an identified reason for information to be not public. You must allow your program to be inspected by licensing agency staff.

What information is public?

- The applicant/license holder name, address and phone number
- License number, license status, services provided under the license, and any limitations on the license
- Licensing actions taken regarding application or license.

How license information is made available

Access information about a license by using the online Licensing Information Lookup search tool on the department's website. See Licensing Information Lookup or http://mn.gov/dhs/general-public/licensing/.

What if I do not want my identifying information made public?

There are circumstances when public identifying information can be limited to ensure the safety of children in foster care. If you believe this applies to you, talk with your licensing worker about limiting public information.

Will licensing information be shared with anyone?

Department staff may give information about you and your program to others authorized under state or federal law. Information is only shared on an as-needed basis to conduct investigations, or provide needed assistance to you or your program.

What if I refuse or withhold information?

Knowingly withholding relevant information, or giving false or misleading information for your license application, may result in denial of your application, or suspension or revocation of a license already issued.

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ያስተውሉ፡ ይህንን ዶኩመንት ለመተርጎም እርዳታ የሚፈልጉ ከሆነ፡ የጉዳዮን ሰራተኛ ይጠይቁ ወይም በሰልክ ቁጥር 1-844-217-3547 ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ သင့်လူမှုရေးအလုပ်သမား အားမေးမြန်း ခြင်းသို့ မဟုတ် 1-844-217-3563 ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

請注意，如果您需要免費協助傳譯這份文件，請告訴您的工作人員或撥打1-844-217-3564。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, demandez à votre agent chargé du traitement de cas ou appelez le 1-844-217-3548.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ တီလံာ်မီတခါအံၤန္ဉ်,သံကွ်ဘဉ်ပှၤဂ့ၢ်ဝီဒုးပှၤမၤစၢၤတ်လၢနဂီၢ်မ့တမ့်ကီးဘဉ် 1-844-217-3549 တကွ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 담당자에게 문의하시거나 1-844-217-3565으로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກ່ຽວກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1 (8-16)

ADA Advisory

For accessible formats of this information or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4671, or use your preferred relay service. ADA1 (2-18)

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center:
Toll-free: 1-800-368-1019
TDD Toll-free: 1-800-537-7697
Email: ocrmail@hhs.gov

DEPARTMENT OF HUMAN SERVICES

DHS-4258B-ENG 9-22

MINNESOTA ADOPTION AND FOSTER CARE

Individual Fact Sheet

NAME OF PERSON COMPLETING FORM	NAME OF APPLICANT/LICENSE HOLDER

Instructions: Family child foster care and adoption applicant(s), license holders, and all adult household members (age 18 and older) are required to complete this form at initial application for a child foster care license or adoption home study, adoption home study update, or at child foster care relicensure.

Do you have a history of, or are you currently experiencing any of the following?

◯ Yes ◯ No Sexual, physical or verbal abuse, or domestic violence.

◯ Yes ◯ No Individual and/or family/group counseling.

◯ Yes ◯ No Treatment or hospitalization for mental health concerns.

◯ Yes ◯ No Criminal charges and/or convictions for any offense (including as a juvenile), even if dismissed.

◯ Yes ◯ No Arrest by law enforcement, or probation/parole.

◯ Yes ◯ No Involvement with social service departments, including child protection.

◯ Yes ◯ No Investigation for neglect or abuse of a child or a vulnerable adult.

◯ Yes ◯ No Out-of-home placement of your own minor children.

If you selected yes to any of the above, explain:

Physical and chemical health statements

1. Do you have any health conditions for which you need medical care?

◯ Yes ◯ No

If yes, describe all health conditions you have and the medical care you are receiving:

2. Do you have health conditions that may pose a risk to a child's health or would limit your physical ability to care for foster children?

◯ Yes ◯ No

If yes, describe the risks or limitations:

3. **Are there minor children living in the home (do not include children in placement)?**
   ◯ Yes ◯ No

4. **Do minor children have any health conditions for which they need medical care?**
   ◯ Yes ◯ No

If yes, describe all health conditions, the medical care they are receiving, and whether or not the condition may pose a risk to foster children:

5. **Have you ever experienced any chemical use problems, including alcohol abuse, abuse of prescription controlled substances, and use of illegal substances?**
   ◯ Yes ◯ No

If yes, describe: (e.g., how long ago, what happened, was treatment recommended, did you attend treatment and/or Alcoholics Anonymous, etc.)

6. **Have you been free of chemical use problems for the past two years?**
   ◯ Yes ◯ No

If no, explain:

Signature

I understand that failure to provide complete and true information on the individual fact sheet may result in denial of my child foster care application; revocation of my child foster care license; or termination of adoption services.

SIGNATURE OF PERSON COMPLETING FORM	DATE

DEPARTMENT OF HUMAN SERVICES

DHS-4258B-ENG 9-22

MINNESOTA ADOPTION AND FOSTER CARE

Individual Fact Sheet

NAME OF PERSON COMPLETING FORM	NAME OF APPLICANT/LICENSE HOLDER

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If yes, describe the risks or limitations:

3. **Are there minor children living in the home (do not include children in placement)?**
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4. **Do minor children have any health conditions for which they need medical care?**
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Signature

I understand that failure to provide complete and true information on the individual fact sheet may result in denial of my child foster care application; revocation of my child foster care license; or termination of adoption services.

SIGNATURE OF PERSON COMPLETING FORM	DATE

DEPARTMENT OF HUMAN SERVICES

DHS-4258B-ENG 9-22

MINNESOTA ADOPTION AND FOSTER CARE

Individual Fact Sheet

NAME OF PERSON COMPLETING FORM	NAME OF APPLICANT/LICENSE HOLDER

Instructions: Family child foster care and adoption applicant(s), license holders, and all adult household members (age 18 and older) are required to complete this form at initial application for a child foster care license or adoption home study, adoption home study update, or at child foster care relicensure.

Do you have a history of, or are you currently experiencing any of the following?

◯ Yes ◯ No Sexual, physical or verbal abuse, or domestic violence.

◯ Yes ◯ No Individual and/or family/group counseling.

◯ Yes ◯ No Treatment or hospitalization for mental health concerns.

◯ Yes ◯ No Criminal charges and/or convictions for any offense (including as a juvenile), even if dismissed.

◯ Yes ◯ No Arrest by law enforcement, or probation/parole.

◯ Yes ◯ No Involvement with social service departments, including child protection.

◯ Yes ◯ No Investigation for neglect or abuse of a child or a vulnerable adult.

◯ Yes ◯ No Out-of-home placement of your own minor children.

If you selected yes to any of the above, explain:

Physical and chemical health statements

1. Do you have any health conditions for which you need medical care?

◯ Yes ◯ No

If yes, describe all health conditions you have and the medical care you are receiving:

2. Do you have health conditions that may pose a risk to a child's health or would limit your physical ability to care for foster children?

◯ Yes ◯ No

If yes, describe the risks or limitations:

3. **Are there minor children living in the home (do not include children in placement)?**
   ◯ Yes ◯ No

4. **Do minor children have any health conditions for which they need medical care?**
   ◯ Yes ◯ No

If yes, describe all health conditions, the medical care they are receiving, and whether or not the condition may pose a risk to foster children:

5. **Have you ever experienced any chemical use problems, including alcohol abuse, abuse of prescription controlled substances, and use of illegal substances?**
   ◯ Yes ◯ No

If yes, describe: (e.g., how long ago, what happened, was treatment recommended, did you attend treatment and/or Alcoholics Anonymous, etc.)

6. **Have you been free of chemical use problems for the past two years?**
   ◯ Yes ◯ No

If no, explain:

Signature

I understand that failure to provide complete and true information on the individual fact sheet may result in denial of my child foster care application; revocation of my child foster care license; or termination of adoption services.

SIGNATURE OF PERSON COMPLETING FORM	DATE

Instructions for completing the Child Foster Care Statement of Intended Use

The child foster care rule requires that the license-holder must work with the licensing agency to develop a statement of intended use. The statement of intended use must be approved by the licensing agency, but it may be changed at any time by agreement with you and the licensing agency in order to reflect any changes that affect the placement of children in your home.

1) Write the number of children you are allowed to care for according to the capacity of your child foster care license. Please note that to provide care for 4 or more children, a fire marshal inspection is required to be completed before you are licensed.

2) Write in the age range of the children for whom you will provide care. Please note that before you transport children under the age of 9, you must complete child passenger restraint training. Also, before you may provide care to children through age 5, you must complete training to reduce the risk of sudden unexpected infant death and training to reduce the risk of abusive head trauma. If you do not plan to provide care for children under these ages, make sure the age range you write on the statement shows that.

3) Write in anything you believe may limit who is placed in your home. An example may be that your home is not handicap accessible. If you cannot think of any limitations, please write in "none."

4) Typically, the adult to child ratio does need to be maintained; however, if there is a reason why it does not need to be maintained, please write in the reason. An example may be that a variance has been granted for a one hour period in the afternoon, when six children will be home with one adult. If there is not a specific reason why the ratio will not be maintained, please write in "none" or "ratio will always be maintained."

5) Please read this item carefully and check yes or no according to whether or not you will provide any of these types of care in your home.

6) This section only needs to be completed by family child foster care license-holders. The purpose of this area is to comply with requirements that determine whether or not you need to also obtain a 245D – Home and Community Based Services (HCBS) license in order to provide respite services. If you provide respite care to children who receive funding under any of the listed waiver plans check "YES" and complete the section below this. If you comply with the two requirements listed, you do not need to also have a 245D – HCBS license to provide out-of-home respite services. You and your licensor should review the parts of 245D that are referenced, and if you agree to comply, then initial each of the two statements on the form.

Signatures: Each applicant or license-holder must sign and date the form. The licensor signs and dates the form also, to show that they have approved the statement of intended use. Remember that the statement can be changed at any time there are changes in the information that is required.

Child Foster Care
Statement of Intended Use

License Holder Name(s): _____

1) The number of foster children our home is licensed for is _____foster children.

2) We will provide foster care to children, age _____through age _____

3) The following limitations will affect the placement of children in our home:

_____

_____

4) Circumstances under which the adult to child ratio of 1-to-5 does not need to be maintained:

_____

5) Our home serves as:

An emergency shelter home ❑ **Yes** ❑ **No**
A program offering short-term, time-limited placements of 90 days of less to children who are in a behavioral or situational crisis, need out-of-home placement in a protective environment, and have an immediate need for services. (Minnesota Rules, part 2960.3010 subp. 39.)

A treatment foster care home ❑ **Yes** ❑ **No**
A culturally relevant, community-based and family-based method by which planned, integrated treatment services are provided to foster children and their parents by foster parents who are qualified to deliver treatment services. . . (Minnesota Rules, part 2960.3010 subp. 43.)

A home for medically fragile children. ❑ **Yes** ❑ **No**
A person who has chronic or acute health condition which requires the routine use of a medical device to assist or maintain a life-sustaining body function and requires ongoing care of monitoring by trained personnel on at least a daily basis. (Minnesota Rules, part 2960.3010 subp. 32.)

THIS SECTION MUST BE COMPLETED BY <u>FAMILY</u> CHILD FOSTER CARE PROGRAMS <u>ONLY</u>

6) Our family child foster care home provides out-of-home respite services to individuals with brain injury, community alternatives for disabled individuals, and/or developmental disability waiver plans. ❑ **Yes** ❑ **No**

- If you checked "No" above, skip the information below this and go directly to the signatures.
- If you have a 245D – Home and Community Based Services (HCBS) license, initial here _____ and go directly to the signatures.
- If you checked "Yes" above, and you do not have a 245D-HCBS license, you must complete the following in order to provide respite services without a 245D-HCBS license.

By initialing below, I assure compliance with the following when providing out-of-home respite services in my child foster care program:

_____I will comply with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, regarding prohibited and restricted procedures, permitted actions and procedures, and positive support transition plans.

_____I will comply with the requirements under section 245D.061, regarding emergency use of manual restraint.

License Holder Signature:_____**Date:**_____

License Holder Signature:_____**Date:**_____

Licensor:_____**Approval Date:**_____

Morrison County Health and Human Services

213 SE First Ave / Little Falls, MN 56345 320-632-7800/ FAX: 320-632-0225

EVALUATION OF THE AGENCY BY CHILD FOSTER CARE HOME

*In order to ensure good communications between our agency and the foster homes, we are requesting some feedback from you regarding your contacts with our agency during the past year.

Please rate the following statements according to:
(5) Strongly Agree
(4) Agree
(3) No Opinion
(2) Disagree
(1) Strongly Disagree

QUESTIONS 1-8 RELATE TO SERVICES PROVIDED BY THE CHILD WORKER.

1. I am able to reach the placement worker when needed or receive a return phone call within a reasonable amount of time. **5 4 3 2 1**
   Comments_____
   _____

2. I know who to contact if the placement worker is unavailable. **5 4 3 2 1**
   Comments_____
   _____

3. I think the licensing and placement worker shares appropriate information about the child (health, school, medical, etc.) at the time of placement. **5 4 3 2 1**
   Comments_____
   _____

4. The placement worker keeps me informed of plans for the child (visits, appointments, etc.) at the time of placement. **5 4 3 2 1**
   Comments_____
   _____

5. I feel that the feedback I give the worker is well received. **5 4 3 2 1**
   Comments_____
   _____

6. I am satisfied with the frequency of planned contact between the placement worker and child. **5 4 3 2 1**
   Comments_____
   _____

7. I am comfortable with contacting the licensing worker and/or placement worker should problems arise. **5 4 3 2 1**
   Comments_____
   _____

8. When there have been problems, I feel that the placement/licensing workers have been concerned and helpful. **5 4 3 2 1**
   Comments_____
   _____

QUESTIONS 9-19 RELATE TO THE FOSTER CARE PROGRAM SERVICES.

9. I receive my reimbursements in a timely manner. **5 4 3 2 1**
   Comments_____
   _____

10. I receive the child information in a timely manner. **5 4 3 2 1**
    Comments_____
    _____

11. I am able to reach the licensing worker when needed or receive a return phone call within a reasonable amount of time. **5 4 3 2 1**
    Comments_____
    _____

12. I am satisfied with the frequency of planned contact between the licensing worker and me. **5 4 3 2 1**
    Comments_____
    _____

13. I am comfortable with the questioning or asking for feedback from the licensing worker. **5 4 3 2 1**
    Comments_____
    _____

14. The licensing worker provides support for the foster providers. **5 4 3 2 1**
    Comments_____
    _____

15. The licensing worker acts as an advocate for foster providers. **5 4 3 2 1**
    Comments_____
    _____

16. The agency foster care emails are informational and helpful. **5 4 3 2 1**
    Comments_____
    _____

17. What additional information in the agency foster care emails would be helpful?
    _____
    _____
    _____
    _____

18. What types of additional training would you like?
    _____
    _____
    _____
    _____

19. What changes would you like to see in the foster care program?

ADDITIONAL COMMENTS:

Signature Date

Licensing Social Worker Date

Agreement between Foster Parents and Child Foster Care Licensing Agency

When children are placed in foster care, their parent/s, the responsible agency (county or Tribal agency that has responsibility for placement), licensing agency and foster parents work together to ensure children's well-being, safety and permanency. All standards and policies in statute, rule and guidance from the commissioner must be understood and followed. **Summary of child foster care responsible agency requirements (DHS-0139A)** should be reviewed with, and a copy provided to, foster parents.

This agreement outlines responsibilities of foster parents and the licensing agency.

Foster care licensing agency agrees to:

1. Assist prospective foster parents with the licensing process by:
   - Providing and reviewing information about family foster care standards and licensing requirements
   - Completing the background study process for applicants and household members
   - Visiting the home to complete a comprehensive home study assessment
   - Considering and processing variance requests.
2. Provide orientation and create ongoing training plans with foster parents to prepare them to meet the needs of children. Required topics include, but are not limited to:
   - Trauma and attachment-informed parenting skills
   - Parenting strategies to affirm and support the racial, cultural and religious identities, and respect sexual orientation and identities, of children in foster care
   - Prudent parenting
   - Skills for trauma-informed parenting to care for children with prenatal exposure to alcohol and children with behavioral and mental health challenges
   - Child passenger restraint systems, sudden unexpected infant death and abusive head trauma prevention, and medical equipment, if applicable.
3. Describe the state's liability insurance coverage provided for licensed foster parents caring for children.
4. Help foster parents make informed decisions as to the suitability of their home to care for specific children and understand that a decision not to take a placement of a child will not jeopardize consideration of their home for other children. If 12 months have passed without accepting a child for placement, agency staff may discuss a plan to close the license.
5. Help foster parents understand the differences between foster care, transfer of permanent legal and physical custody, and adoption.
6. Discuss agency practices to assist foster parents interested in becoming a permanency resource through adoption or transfer of permanent legal and physical custody for children who cannot be reunified with their parents/guardians, including children statewide.
7. Investigate licensing reports to determine compliance with requirements.
8. Provide foster parents with written and verbal opportunities to evaluate licensing agency practices.
9. Include foster families in annual evaluations of their performance, including their roles and responsibilities, support needs and outcomes of placements for children in their home.
10. Notify the commissioner immediately upon learning about safety concerns that may affect children.

Foster parents agree to:

1. Allow representatives of the responsible social services and licensing agencies and/or commissioner of the Minnesota Department of Human Services access to their home and property for the purpose of licensing, placement and supervision.
2. Acknowledge that their role as foster parent is intended to be temporary. Foster parents are expected to support reunification and transitions to foster or permanency homes in accordance with the case plan and court orders.
3. Accept children for foster care placement as described in the statement of intended use.
4. Contact licensing agency to inform of possibility of accepting placement of child/ren if contacted by a placing worker.

5. Notify licensing worker within 24 hours of accepting placement of a child.
6. Regularly engage with a child's parents/guardians to facilitate a co-parenting relationship when the goal is reunification, unless such a relationship poses a danger to the mental or physical health of child or foster parent/s.
7. Actively cooperate and participate with the responsible agency case manager and other involved service providers to develop and implement child's out-of-home placement plan, including visitation and preserving family relationships.
8. Provide for child's needs, including food, clothing, shelter, daily supervision, school supplies, personal needs and, consistent with the out-of-home placement plan, provide timely access to medical and dental care, including prescription medications and mental health services by qualified professionals.
9. Develop a plan for a smoke-free home environment for children in foster care.
10. Provide supervision in accordance with a child's age and needs, as assessed in the Minnesota Assessment of Parenting for Children and Youth (MAPCY).
11. Immediately report a missing foster child to the responsible county or Tribal agency and provide sufficient information on when they left, what they were wearing and other relevant information that will facilitate the agency staff to actively search for the child. If unable to contact county or Tribal case manager immediately, call their agency's 24-hour coverage line or law enforcement.
12. Report to the responsible agency plans to take child out of state, when they will be away from the foster home for longer than three nights, any changes in household members or plans to move, any serious family illness and any serious illness or accident involving a child in their care for foster care.
13. Make meaningful effort to increase understanding of, and demonstrate respect for, the religious, racial and cultural heritage, as well as sexual orientation and gender identity of children in their care and their families.
14. Acknowledge the effect of trauma and difficulties children in foster care may experience adjusting to a new environment. Make every effort to understand and be patient in addressing challenging behaviors of a child that result from the impact of trauma, separation and the grieving process. This may include participation in therapy and other services, as directed by the out-of-home placement plan or arranged by the responsible county or Tribal social service agency.
15. Ensure child's personal property and funds in the foster home are available for their use (unless restricted in their out-of-home placement plan). If a child is removed from the home, their property and funds, including any that were accumulated during placement, are returned within three days of removal.
16. Support placement stability for children by asking for consultation and direction from the responsible agency if issues arise that cannot be resolved between foster parents and child. Prior to requesting removal of a child, foster parents must work with the responsible agency to determine if additional strategies or support services may resolve issues leading to a request for removal. When all resources are exhausted, provide the responsible agency with sufficient time (45 days, if possible) to plan for discharge.
17. Allow the responsible agency caseworker and child to meet alone.
18. Immediately notify the licensing agency of:
    - Any changes to the license holder or household members' physical or behavioral health that may affect the license holder's ability to care for a foster child or pose a risk to a foster child's health
    - Police contact at the foster home
    - Incidents that may result in criminal or delinquency charges for an applicant or household member
    - Other safety concerns that affect a child.
19. Comply with requirements of the Family Foster Care Confidentiality Agreement, Attachment A, incorporated in this agreement.

By signing below, I, as the applicant or licensed foster parent, acknowledge that I have received a copy and have read this document and understand my responsibility to maintain confidentiality of information provided to me regarding foster child/ren in my care.

We understand the policies and practices, and our respective roles. We agree to carry out our responsibilities and always comply with requirements in Minnesota Statutes and Rules while providing foster care to children.

FOSTER PARENT _____ DATE _____

FOSTER PARENT _____ DATE _____

CHILD FOSTER CARE LICENSING WORKER _____ DATE _____

Clear Form

Attachment A: Child Foster Care Confidentiality Agreement

A. Foster parents, having access to not public information* about a foster child and their family, agree not to discuss or otherwise disclose that information to any other person prior to the child's placement in foster care, while they are in a foster home, or after they leave a foster home, except to the following:

(1) **The licensing agency.**

(2) **The responsible social services agency.**

(3) **Those involved in the child's treatment plan.** Foster parents must identify and share information, if appropriate, with persons who are directly involved in the child's treatment plan. A treatment plan is a written plan for intervention, treatment and services for children in a foster setting.

(4) **Child's respite care, substitute care providers and short-term babysitters.** Foster parents must give these providers information needed to care for children, including their emotional, behavioral, medical and physical health conditions; medications child takes; and names and telephone numbers of individuals to contact in case of an emergency, including how to obtain medical care.

(5) **Child's medical and dental care providers.** When foster parents obtain routine or emergency medical and dental care for child, they may share or obtain necessary information.

(6) **Foster child's child care providers.** When foster parents enroll a child in a child care program, they may communicate to providers necessary information to care for them, including information required in an application for a child care program.

(7) **Child's education professionals.** When foster parents enroll a child in school according to their out-of-home placement plan, foster parents may communicate to school staff necessary information to educate children, including information required for enrollment in school.

(8) **Child's extracurricular, social or cultural activity programs.** When foster parents enroll a child in extracurricular, social or cultural activities under the reasonable and prudent parenting standard, they may communicate to organization staff necessary information for a child to enroll and participate in activities.

B. Foster parents agree not to share any not public information about a foster child and their family with neighbors, family members of foster parents not approved by the responsible agency to receive information, or others who do not provide services or care to foster children. Foster parents agree not to share not public information about foster children and their family on social media, unless otherwise approved by the responsible agency.

C. Foster parents agree that if they are unsure about any restriction of information, how to maintain written records related to foster children or record retention, they will discuss these questions with the county or Tribal agency that has responsibility for placement.

*As defined by **Minnesota Statutes 13.02, subd. 8a**.

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Office for Civil Rights
U.S. Department of Health and Human Services
Midwest Region
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Customer Response Center:
Toll-Free: 800-368-1019
TDD Toll-Free: 800-537-7697
ocrmail@hhs.gov

For accessible formats of this information, ask your county worker.
For assistance with additional equal access to human services, contact your county's ADA coordinator. (ADA4 [2-18])

NO ENGLISH  **651-431-4660**

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤန့ဉ်,ကိးဘဉ်လီတဲစိနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

XHubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Summary of Child Foster Care Responsible Agency Requirements

A county or tribal agency must have placement responsibility for a child's foster care placement. This may be a court order or a voluntary placement agreement. The responsible agency's role and responsibility is determined in law and tribal code, and is reviewed in court. The following applies to most placements:

1. Consider foster care a temporary living situation for a child. The responsible agency's staff concurrently plan for a child to be safely reunited with their parent(s) and at the same time seek other families, first considering relatives and kin, to permanently care for a child if they cannot return home because of safety concerns.
2. Diligently search and notify a child's maternal and paternal relatives and kin of their need for foster parents. The agency will search for and notify relatives until the court is satisfied with agency efforts.
3. Place a child with their siblings. If siblings cannot be placed together safely, the agency must ensure that they have regular visitation and contact.
4. Provide foster parents with information about a child before placement as part of the out-of-home placement plan (OHPP), or as information becomes available, including:
   - The reason(s) foster care is needed.
   - The permanency plan for a child
   - A child's medical history, immunization record, or any other medical or dental needs
   - A child's educational needs and school enrollment.
5. Include foster parents in development and implementation of the OHPP, assessing and including services needed in the foster home to ensure a child's well-being, and supporting placement stability. Foster parents must be provided with a copy of the OHPP.
6. Send foster parents written notice of all administrative review and/or court hearings, and ensure that they are aware of their right to attend court hearings and their right to be heard.
7. Visit a child monthly, with a majority of those visits to take place in the family foster home. These visits support placement stability and help a child and their foster parents address any problems they may be having. These visits should:
   - Assess a child's daily needs and foster parent concerns about a child's behavior and development to ensure their needs are safely being met in the home, as well as the need for additional services.
   - Ensure a child's health needs are met.
   - Ensure that child is attending school.
   - Review the case plan, including a child's participation in age-appropriate social, extracurricular and cultural enrichment activities.
   - Engage foster family in an ongoing discussion and evaluation about their roles and responsibilities, and their need for support during a child's placement.
   - Report any concerns about a child's care to child protection and the licensing agency.
8. Explain the importance of family visitation to develop or preserve a child's bond with their parents and siblings, and establish a visitation plan that schedules visits so child's parent(s), foster parents and child can plan accordingly. Help foster parents understand that visitation may affect a child's behavior, and assist them to develop strategies that will support a child to maintain relationships with their parent(s) and siblings.
9. Inform foster parents about Northstar Care for Children. The agency assesses every child entering foster care for a basic and supplemental payment using the Minnesota Assessment of Parenting for Children and Youth (MAPCY). Provide a copy of "What is the MAPCY assessment?" (DHS 7060A).
10. Ensure that a child's educational and health care needs are assessed and issues identified are appropriately addressed, including physical, mental, chemical, developmental, dental and visual health needs, as follows:
    - Provide clear instructions to foster parents in the OHPP about their role and responsibility in meeting a child's health care needs while in their care.
    - Involve a child's parent(s) in planning for their education and health care. The parents make educational and treatment decisions unless parental rights have been terminated, or the court has restricted parents' involvement in planning and providing for their child's well-being.
    - Provide foster parents with information necessary to enroll child in school, as well as in the free and reduced lunch program, and similar programs.
11. If a foster parent asks the responsible agency to remove a child from their home, prior to removal they and agency staff will work together to determine if additional supports or services can safely maintain a child in the home. A foster child experiences an unplanned move only when an agency is concerned about their health or safety, or when all resources to support placement stability have been exhausted. Unless agency staff determines that there is an issue that affects a child's health or safety, it will remove a child from the foster home within 45 days of a request.

Clear Form

Agency Use: Enter a contact number that can assist with a request to interpret this document.

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့ၢ်. ဖဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီလၢတၢ်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မိတခါအံၤနူဉ်,ကိးဘဉ်လီတဲစိနိၣ်ဂ်ၢ်လၢထးအံၤနူဉ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA Advisory

For accessible formats of this publication, ask your county worker.
For assistance with additional equal access to human services, contact your county’s ADA coordinator. (ADA4 [9-15])

DEPARTMENT OF HUMAN SERVICES

DHS-8313-ENG 6-24

OFFICE OF INSPECTOR GENERAL - LICENSING DIVISION

Child Foster Care and Child Foster Residence Setting Home Safety Checklist

Prior to licensure the foster home must be inspected by a licensing agency employee using the home safety checklist from the Commissioner of human services (Minnesota Rules, part 2960.3050, subpart 1)

NAME OF LICENSE HOLDER/PROGRAM

Emergency procedures

The following items must be posted and/or readily accessible in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident.

◯ Yes ◯ No	A list of emergency phone numbers.
◯ Yes ◯ No	A written fire/emergency escape plan.
◯ Yes ◯ No	An operable flashlight and radio or television set that does not require electricity.
◯ Yes ◯ No	Accessible first-aid supplies.
◯ Yes ◯ No	An operable telephone.

Physical environment

◯ Yes ◯ No	Exit doors and windows are not obstructed and are easily opened from the inside.
◯ Yes ◯ No	The wiring appears safe; no known hazards exist.
◯ Yes ◯ No	Extension cords are appropriately used and are not used in place of permanent wiring.
◯ Yes ◯ No	A fire extinguisher with a minimum rating of 2A:10BC is maintained in the home.
◯ Yes ◯ No	All smoke detectors work and are properly installed on all levels of the home.
◯ Yes ◯ No	All interior doors can be unlocked from the outside and the opening device is readily accessible in case of emergency.
◯ Yes ◯ No	The home is clean and free from accumulations of dirt, grease, garbage, peeling paint, vermin and insects.
◯ Yes ◯ No	Outside property is free from debris and safety hazards. Exterior stairs and walkways are free of ice and snow.
◯ Yes ◯ No	When in use, fireplaces, wood burning stoves, and hot surfaces that could cause burns are protected by guards.
◯ Yes ◯ No	The heating system in the home is maintained in good working condition.

Home safety and health

◯ Yes ◯ No	Knives, tools, matches, and other potentially hazardous materials are not accessible based on age, and identified safety concerns and behaviors specific to each foster child in care.
◯ Yes ◯ No	Chemicals, detergents, and other toxic substances are not stored with food products or accessible in any way that poses a risk to children.
◯ Yes ◯ No	Combustible items are properly stored at least 36" from any heating sources.
◯ Yes ◯ No	Individual clean bed linens, towels, and wash cloths are provided for each foster child.
◯ Yes ◯ No	Food is handled and properly stored to prevent contamination, spoilage, or a threat to the health of children.
◯ Yes ◯ No	Medication is not accessible to children based on age and/or identified safety concerns.
◯ Yes ◯ No ◯ N/A	Schedule I and Schedule II controlled substances are stored in a locked area.
◯ Yes ◯ No ◯ N/A	Cannabis products are clearly labeled and stored in a locked storage area.
◯ Yes ◯ No	There is a safe water supply in the home.
◯ Yes ◯ No	The water temperature does not exceed 120 degrees Fahrenheit in order to prevent scalding.
◯ Yes ◯ No ◯ N/A	Weapons and ammunition are stored separately in locked areas that are not accessible or visible to foster children. Weapons include firearms and other instruments or devices designed for and capable of producing bodily harm.

Sleeping space for foster children and reduction of risk of Sudden Unexpected Infant Death

◯ Yes ◯ No	The sleeping space for foster children has two exits.
If sleeping space for foster children is in an area not normally used for sleeping, describe the alternative sleeping arrangements. Has a variance been approved for an alternative sleeping arrangement?	
◯ Yes ◯ No	Will care be provided to infants?

If yes, complete the following six questions:

◯ Yes ◯ No	A safe crib is available and used for each infant in care. (Before placing an infant in foster care, the agency must verify that there is a safe crib in the home).
◯ Yes ◯ No	Infants younger than one year of age in care will be placed to sleep on their back, in a crib, directly on a firm mattress.
◯ Yes ◯ No	If an infant will not be placed to sleep on their back, there is documentation from the infant's physician, advanced practice registered nurse, or physician assistant directing an alternative sleeping position for the infant. The directive must be on a form approved by the commissioner.
◯ Yes ◯ No	The crib's firm mattress has a fitted sheet, appropriate to the mattress size that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort.

◯ Yes ◯ No	Nothing will be placed in the crib with the infant except for the infant's pacifier. The pacifier must be free from any sort of attachment.
◯ Yes ◯ No	Minnesota Statutes, section 245A.1435 Reduction of Risk of Sudden Unexpected Infant Death in Licensed Programs has been reviewed by all caregivers. All caregivers agree to comply with the requirements of this section.

Safety hazards or concerns

If applicable, document obvious safety hazards or concerns and any follow-up required. Include the date each item was corrected for a new application or the date a correction order was issued for an existing license:

	Description of safety hazard or concern and any follow-up
1.	
2.	
3.	
4.	
5.	
6.	

Signatures

Signature of applicant/license holder

SIGNATURE	DATE

Signature of agency worker

SIGNATURE	DATE

Items on this home safety checklist must not be altered or deleted.

Fire Extinguisher Reservicing

- **Innovative Fire Safety Solutions**
  - Pierz, MN
    - 320-310-3788

- **Yager Fire Protection**
  - Little Falls, MN
    - 320-267-2351

- **Z-Mann Fire Protection and Power Washing**
  - Little Falls, MN
    - 320-431-9476

- **Nardini**
  - Baxter, MN
    - 218-765-3450

- **St. Cloud Fire Equipment**
  - St. Cloud, MN
    - 320-252-5562

- **Northland Fire Equipment**

- Brainerd, MN
  - 218-829-5969

Updated 1/2023

MORRISON COUNTY

Morrison County provides cost effective, high quality services to county residents in a friendly and respectful manner.

Health and Human Services
Nathan Bertram
Director

213 South East First Avenue
Little Falls, Minnesota 56345-3196
www.co.morrison.mn.us
General Information: 320-632-7800
Fax: 320-632-0225

Water Testing Laboratories:

9502.0445. Subpart 1. Water. There must be a safe water supply in the residence. A. Water from privately owned wells, must be tested annually by a Minnesota Health Department certified laboratory for coliform bacteria and nitrate nitrogens to verify safety. The provider shall file a record of the test results with the agency. Retesting and corrective measures may be required by the agency if results exceed state drinking water standards or where the supply may be subject to off-site contamination.

Water testing clients are referred to the following water testing laboratories. Please contact them directly to request a kit for: **Coliform/E-coli and Nitrates.**

Certified Labs: (for routine, real estate transactions & day/foster care tests)

A.W. Research Laboratories
314 Charles Street
Brainerd, MN 56401
218-829-7974

Central Water Testing Laboratory (AquaCare)
18511 State Hwy 371
Brainerd, MN 56401
Phone: 218-828-2118 Toll Free: 888-689-6070

Traut Water Analysis Lab
141 28 Avenue South
Waite Park, MN 56387
Phone: 320-251-5090
2 test kits (bags) provided; encourage personal delivery to lab

Water Laboratories Inc.
333 East Main St
Elk River, MN 55330
Phone: 763-441-7509
*(*Discount for Dairyland Lab customers)*

RMB Environmental Lab
22796 County Highway 6
Detroit Lakes, MN 56501
Phone: 218-846-1465
Our partnered locations have sampling kits available for pick-up Monday – Thursday during normal business hours. A territory representative will provide complimentary delivery to our lab using the schedule of

Distribution Partners linked: rmbel.info/wp-content/uploads/2019/04/Distribution-Partner-List.Flyer_.Rev-02.07.19.pdf

Traut Wells
754 Cross Country Lane SW
Alexandria, MN 56308
320-762-1528

Non-Certified Lab: (personal/routine use)

Dairyland Laboratories
919 Lincoln Avenue
Sauk Rapids, MN 56379
Phone: 320-240-1737

Submit your receipt to your licensor for reimbursement.