

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



DISTRICT OF COLUMBIA  
EMERGENCY TEMPORARY LICENSE  
PACKET

EMERGENCY TEMPORARY PROVIDER'S NAME \_\_\_\_\_

SOCIAL WORKER'S NAME \_\_\_\_\_ TELEPHONE  
NUMBER \_\_\_\_\_

SUPERVISORY SOCIAL WORKER \_\_\_\_\_ TELEPHONE  
NUMBER \_\_\_\_\_

AGENCY REQUESTING LICENSE \_\_\_\_\_

**PRIVATE AGENCIES:** Please provide submitting worker and supervisor's e-mail address below.

SOCIAL WORKER E-MAIL \_\_\_\_\_ SUPERVISOR E-MAIL \_\_\_\_\_

**TO BE FILLED OUT AT TIME OF SUBMISSION BY LICENSING OFFICE**

DATE RECEIVED \_\_\_\_\_ RECEIVED BY \_\_\_\_\_

COMMENTS:

DISTRICT OF COLUMBIA  
EMERGENCY TEMPORARY LICENSURE TIP SHEET

**Who is eligible?**

Residents who reside in the District of Columbia and meet the requirements of being a Kinship Care Provider.

**How do I initiate the Process?**

An assigned social worker can initiate this process by downloading an Emergency Packet from the intranet or contacting Tamara Smith-Jackson on 202-727-3893. Once a packet has been obtained by the social worker, that worker then completes the packet **along with the prospective provider**. Once completed, **the worker submits** the packet to Tamara Smith-Jackson, 200 I Street, SE, 3<sup>rd</sup> Floor

THIS PACKET SHOULD BE COMPLETED WITH THE SOCIAL WORKERS ASSISTANCE.

This office will only accept an emergency packet from a social worker and **not** potential provider(s).

**The following forms are included in the packet:**

---

**1. Assessment Tool For Placement of Children in Kinship Home:**

*(must be completed by worker)*

This document contains a safety assessment checklist as well as a clinical narrative on the last page. Please make sure to include sleeping arrangements for all household members, ages and sex of children already residing in the home and those to be placed.

**2. Clinical Home Study Assessment:** must be completed by the worker, please refer to the format and guidelines provided in the packet.

**3. The Application for Temporary License to Operate a Foster Home.**

**4. Agency Policy on Discipline and Corporal (Physical) Punishment.** This form must be signed by perspective provider(s).

**5. Relative Affidavit. (If Applicable).** This form **needs** to be notarized. This form is only utilized to denote relationship to the child and should be submitted when the prospective provider is not biologically related to the child/children. This form must be completed by the biological parent or another viable adult family member to denote that the potential provider has a previous relationship with the child/children. **Again, this form is not needed if the potential provider is biologically related to the child to be placed.**

**6. NCIC-Interstate Identification Index (Triple I) File Check Request Form.**

Notarization is not mandatory if witnessed by a CFSA Social Worker. The Triple I form must be completed by all household members 18 years or older in its entirety and submitted along

with the Emergency Temporary Packet. A separate form must be filled out for each household member who needs to be checked.

- *All household members, 18 and older, will be contacted by phone for scheduling of livescan(FBI)/fingerprints. This procedure will be done on site at 200 I Street, SE*

**7. Child Protection Register Check-License to Operate a Foster Home.** *Note: This form must be notarized. This form must be completed by the perspective provider and all others 18 years of age or older who reside in the foster home. A separate form must be filled out for each household member who needs to be checked. If the applicant has resided in the state of Maryland within the past 7 years, they must complete the attached MD CPC form.*

**8. Lead Paint Referral Form:** This form must be completed for children being placed in a home who are under six (6) years old.

**9. Training Letter.**

This form is to be signed by the prospective providers agreeing to complete the MAPP Foster Parent Training. Please note it is the responsibility of the social worker to make an appropriate assessment as to the availability of the potential provider to attend training classes. **These classes occur mainly in the evening.** A temp license will not be granted unless this letter is signed by both the social worker and provider(s).

**NOTE:**

**PLEASE PROVIDE APPLICANT WITH THE ATTACHED INFORMATION TO SCHEDULE REQUIRED FIRE INSPECTION**

***\*\*Packets not fully completed will be returned to the social worker and will not be processed\*\****





**Applicant Signature and Attestation:**

I understand and agree that:

1. I am applying for a temporary license to operate a foster home in order to have the child(ren) identified in Part I above, placed in my home.
2. In order for me to receive a temporary license to operate a foster home I must: receive a satisfactory criminal records check from the Interstate Identification Index System; ; comply with requirements concerning a Child Protection Register check; receive a satisfactory safety assessment of my home; and demonstrate the willingness and ability to provide a safe and secure environment for a foster child.
3. In order for me to receive a temporary license to operate a foster home all individuals eighteen (18) years of age or older residing in my home must: receive a satisfactory criminal records check from the Interstate Identification Index System; and comply with requirements concerning the Child Protection Register check.
4. If a temporary license is issued to me I will actively and promptly take all steps required for full foster home licensure.
5. A temporary license will permit me to operate a foster home prior to issuance of a full foster home license to operate a foster home and while I attempt to satisfy the requirements for a license.
6. A temporary license will expire in one hundred fifty (150) days from its effective date.
7. A foster child who is not kin to me will not be placed in my home while I have a temporary license.

The information in this Application for Temporary License to Operate a Foster Home is true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
*Signature Prospective Provider 1*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature Prospective Provider 2*

\_\_\_\_\_  
*Date*

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



## AGENCY POLICY ON DISCIPLINE AND CORPORAL (PHYSICAL) PUNISHMENT

Child and Family Services Agency is mandated by law (D.C. Law 2-22- Prevention of Child Abuse and Neglect Act of 1977) to report child abuse and neglect. According to this law, an abused child is "a child under eighteen (18) years of age whose parent, guardian or custodian inflicts or fails to make reasonable efforts to prevent the infliction of physical, mental, and/or sexual abuse or molestation." Corporal punishment means the inflicting of pain or discomfort. Prohibited actions include, but are not limited to, hitting with any part of the body or with an instrument, pinching, pulling, shaking, binding a child, forcing him/her to assume an uncomfortable position, or locking him/her in a room or closet. "Emotional neglect is a significant impairment of the child's emotional ability to function adequately and which is caused by action or inaction of person(s) responsible for his/her care."

This prohibition is in effect whether punishment is spontaneous or a deliberate technique for effecting behavior change or part of a behavior management plan.

In addition to being mandated by law, Child and Family Services Agency believes that children who have been abused (physically and sexually) and neglected, must not be subjected to corporal (physical) punishment or emotional neglect in foster or adoptive homes. Therefore, the following policy is in effect:

1. Foster parents, adoptive parents, members of their families, volunteers and other substitute caretakers (who are approved by the foster or adoptive parents and agency) **may not** use corporal (physical) punishment as a disciplinary method.
2. Foster parents, adoptive parents (and others as noted above) **may not** use emotional neglect or verbal abuse as a disciplinary method.
3. Foster and adoptive parents **may not** give others permission to use corporal punishment toward any child under the supervision of the agency's care or responsibility.
4. All instances of corporal punishment or emotional neglect must be reported to Child and Family Services Agency and the Local Social Services agency/Police department where the foster family resides.
5. Child and Family Services Agency staff is prepared to partner with foster/adoptive parents in developing appropriate methods for discipline of the foster children in their care.

6. The Child and Family Services Agency supports the judicious use of alternatives to corporal (physical) punishment such as:
- A. Be a Role Model
  - B. Provide the Child with Time Out
  - C. Provide Positive Reinforcers and Privileges
  - D. Take away Privileges
  - E. Ignore the Behavior
  - F. Provide Natural and Logical Consequences
  - G. Ensure that Restitution Occurs
  - H. Hold Family Meetings
  - I. Develop Behavioral Charts
  - J. Use Grandma's Rule or This for That
  - K. Help the Child Understand Feelings
  - L. Replace Negative Time with Positive Time
  - M. Provide Alternatives for Destructive Acting-Out Behaviors
  - N. Make a Plan for Change with the Child
  - O. Make a Plan for Change with the Child and a Professional

The Child and Family Services Agency Social Worker will provide additional guidance on the important role of disciplining foster/adoptive children upon request.

**I have read and understand the above policy and agree to abide by it.**

Signature	Title	Date
Signature	Title	Date

**This form only has to be completed and NOTORIZED if the potential provider IS NOT biologically related to the child to be placed.**

RELATIVE AFFIDAVIT

I, [ ] state that the following is true to the best of my knowledge,  
Biological Parent/Relative

Information and belief:

1. I am [ ] by [ ]  
Relationship to child select one: blood, marriage or adoption

of [ ]  
Child's name

[ ] is a [ ] who was born in  
Child's Name Gender

[ ]  
Place of Birth

2. [ ] has a relationship with child  
Prospective provider(s) name

based on [ ]

]

(Explain Connection, i.e. Babysitting, weekend care, etc.)

3. [ ] has close personal and emotional ties with  
Prospective provider(s) name

[ ] and with [ ], and  
Child's Name Child's Family Name

those ties pre-dated [ ] placement in CFSA's  
Child's Name custody.

[ ]  
Potential Provider(s) Name

4. I hereby swear or affirm that the contents of this Relative's Affidavit are true and correct to the best of my knowledge, information and belief.

[Full Name]

Address

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



NCIC

INTERSTATE IDENTIFICATION INDEX (TRIPLE I) FILE CHECK REQUEST FORM

**INSTRUCTIONS:**

This form is used for a Triple I Check requested in connection with either an application for a temporary license from the D.C. Child and Family Services Agency to operate a foster home.

\*Each person applying for a temporarily license, as well each person living in the household (temporary or permanently) of the person who is applying to for a temporary license and who is 18 years of age or older, must receive a Triple I check. A separate form is required from each person.

Print or type all information.

**I: Person to be Checked**

NAME: \_\_\_\_\_  
Last First Middle

D.O.B. \_\_\_\_\_ Social Security No. \_\_\_\_\_ -- --

Race: \_\_\_\_\_ Gender: Male Female (Circle One)

List all names ever used (maiden, married alias, etc.; continue on additional pages if needed):

\_\_\_\_\_

\_\_\_\_\_

**II. Person(s) Applying for Temporary License**

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last First Middle Initial

ADDRESS: \_\_\_\_\_  
No. & Street City State

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Last First Middle

ADDRESS: \_\_\_\_\_  
No. & Street City State

**III: Name of child (ren) to be placed in home**

NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		
NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		
NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		
NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		
NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		
NAME	_____	_____	_____	D.O.B.	_____
	Last	First	Middle Initial		

**IV: Signature and Attestation –**

**\*\*IF THE SIGNATURE IS NOT PERSONALLY WITNESSED BY A CFSA STAFF MEMBER, THIS FORM MUST BE NOTARIZED.**

1. I understand and agree that this Triple I Check is being made in connection with the application for a temporary license to operate a foster home made by the person(s) identified in Part II, above.
2. I understand and agree that the result of the Triple I check will be provided to relevant CFSA's foster home licensing and monitoring staff, as well as relevant staff of the child placing agency through which the licensing application is made (if different).
3. I understand and agree that the results of the Triple I check may also be shared with:
  - The individual who is applying for the temporary license to operate a foster home if the results of the check are relevant to the decision whether to grant the license;
  - The Family Court if the results of the check are relevant to the court proceedings concerning a foster child who is or would be placed in the home; and
  - CFSA Office of Hearings or the District's Office of Administrative Hearings if the results of the check are relevant to a fair hearing concerning the temporary license to operate a foster home.

The information in this Interstate Identification Index (Triple I) is true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Worker's Signature

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

V. *This section is to be completed by CFSA staff member*

*To be completed by staff performing check:*

*Date of Triple I Check:* \_\_\_\_\_

*Person conducting Check:* \_\_\_\_\_

\_\_\_\_\_ *Person is not listed*

\_\_\_\_\_ *Person is listed*



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
CHILD AND FAMILY SERVICES AGENCY



Entry Services Division

Kinship Family Licensing Unit

EMERGENCY PLACEMENT

Biometric Live scan Criminal Background Check Request Form

Booking ID # 017

FACES Provider ID # \_\_\_\_\_

Provider Name \_\_\_\_\_  
Name that will appear on the license

Placement Child (ren): \_\_\_\_\_

Licensing SW/Requester \_\_\_\_\_

Log Date \_\_\_\_\_

Live scan Operator \_\_\_\_\_

Date Scanned \_\_\_\_\_

Applicant Types:

Emergency Temp Placement License

Backup Child Care Provider

Do you reside in the home of the Emergency Temp. License parent?

YES \_\_\_\_\_ NO \_\_\_\_\_

Name of person fingerprinted: \_\_\_\_\_  
(Please Print) First Middle Last

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  Race \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Country of Citizenship \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Photo ID Type:  Gove.  Military  Drivers  State ID Number \_\_\_\_\_

Residence of person fingerprinted \_\_\_\_\_  
Street City State Zip. Code

Phone Numbers \_\_\_\_\_  
Home Work (only if you are reachable) Cell

**Please read and sign below**

I confirm that the above information is true to the best of my knowledge and agree to undergo a criminal background check including but not limited to the DC Metropolitan Police Department (MPD) and the FBI.

Signature of person fingerprinted: \_\_\_\_\_



GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



**Child Protection Register Check Application**  
**License to Operate a Foster Home (CPR Check – foster home license)**  
**EMERGENCY TEMPORARY LICENSE ONLY**

This form is used for a CPR Check requested in connection an application for a license from the D.C. Child and Family Services Agency to temporarily operate a foster home.

**INSTRUCTIONS:** Please PRINT or TYPE, filling in all requested information, and sign in the places marked "Applicant Signature." Please do not use initials to represent your first or middle name. However, if your first or middle name consists of only an initial, please indicate. A complete street address is required in addition to P.O. Box numbers.

Each person living in the household (temporarily or permanently) of the person who is applying to be a foster parent (including a temporary foster parent) and who is 18 years of age or older, must complete a separate CPR Check Application.

**PART I: Applicant Information**

NAME: _____			
_____	_____	_____	
Last	First	Middle	
D.O.B. _____		Social Security No. _____	
_____	_____	_____	
Month	Day	Year	
Race: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
List all names ever used (maiden, married, alias, etc.; continue on additional pages if needed):			
_____			
_____	_____	_____	
Last	First	Middle	
_____			
_____	_____	_____	
Last	First	Middle	
_____			
_____	_____	_____	
Last	First	Middle	
_____			
_____	_____	_____	
Last	First	Middle	

**PART II: Licensee Information** Provide the following information concerning the individual seeking the license to operate a foster home. If the same as the person identified in Part 1, above, write "same".

NAME: _____		
Last	First	Middle
D.O.B. _____		Social Security No. _____
Month	Day	Year
Race: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

**PART III: Household Information** List all persons living at the current address. Print their Name, Date of Birth, and Relationship below.

NAME (Last, First, Middle)	D.O.B	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PART IV: Applicant Residency** List all complete addresses (exclude zip code) at which the individual has resided in the past eighteen (18) years, and the dates lived there, beginning with the most recent. Continue on additional pages if needed.

No. & Street (include apt. number if applicable)	City	State	Dates of Residency
_____	_____	_____	_____
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
_____	_____	_____	_____
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
_____	_____	_____	_____
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
_____	_____	_____	_____
No. & Street (include apt. number if applicable)	City	State	Dates of Residency
_____	_____	_____	_____

**PART V: Applicant Release**

1. I understand and agree that this Child Protection Register Check Application – Emergency Temporary License to Operate a Foster Home is being made in connection with the application for a license to operate a foster home made by the person identified in Part II, above.
2. I understand and agree that the result of the CPR check will be provided to relevant CFSA foster home licensing and monitoring staff, as well as relevant staff of the child placing agency through which the licensing application is made (if different).
3. I understand and agree that the result of the CPR check may also be provided to relevant CFSA or contract agency staff providing case management services to a foster child who is or may be placed in the foster home.
4. I understand and agree that the results of the CPR check may also be shared with:
  - The individual who is applying for the license to operate a foster home if the results of the check are relevant to the decision whether to grant the license;
  - The Family Court if the results of the check are relevant to the court proceedings concerning a foster child who is or would be placed in the home; and
  - CFSA Office of Fair Hearings and Appeals or the District of Columbia’s Office of Administrative Hearings if the results of the check are relevant to a fair hearing concerning the license to operate a foster home.

**PART VI: Applicant Signature and Attestation** This form must be notarized unless identification is shown to a CFSA staff member who has signed below.

The information in this Child Protection Register Check Application – License to Operate a Foster Home is true and correct to the best of my knowledge, information and belief.

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Identification has been shown to me that I have deemed satisfactorily identifies the applicant::

Type of ID \_\_\_\_\_ ID # \_\_\_\_\_

Witnessed by CFSA staff member:  
\_\_\_\_\_

Name printed: \_\_\_\_\_

Title: \_\_\_\_\_

DISTRICT OF COLUMBIA:

Subscribed and affirmed or sworn to me, in my presence,

on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature of Notary Public

\_\_\_\_\_  
Notary Public, District of Columbia

My commission expires on \_\_\_/\_\_\_/\_\_\_

**PART VII: Agency Information** (Please review entire application before forwarding to the CFSA CPR Office).  
MAIL COMPLETED ORIGINAL FORM TO:

Child and Family Services Agency  
400 6<sup>th</sup> Street, SW  
Washington, DC 20024  
Attn: Child Protection Register

➤ **TO BE COMPLETED BY REFERRING AGENCY REQUESTING RESPONSE VIA MAIL:**

Agency Name: CFSA-Kinship Family Licensing Unit Phone Number: 202-727-3893  
Email Address (optional): tamaral2.smith@dc.gov Cubicle/Room #: \_\_\_\_\_  
Address: 200 I Street, SE City: Washington  
State: DC Zip Code: 20003 Attention: Smith-Jackson, Tamara  
Last Name First Name

➤ **TO BE COMPLETED BY REFERRING AGENCY REQUESTING RESPONSE VIA FAX:**

Please fax the response to: \_\_\_\_\_  
(Agency Name)  
Attention: \_\_\_\_\_  
(Designated Agent)  
Fax Number \_\_\_\_\_

\*\*\*\*\*  
I UNDERSTAND THAT I WILL NOT RECEIVE AN ORIGINAL COPY IN THE MAIL IF I REQUEST A  
FAXED COPY. \_\_\_\_\_  
(Initials)

State of Maryland-Child Protective Services Program  
**CONSENT FOR RELEASE OF INFORMATION/BACKGROUND CLEARANCE REQUEST**

**INSTRUCTIONS**

1. Type or print legibly in ink. INCOMPLETE FORMS WILL BE RETURNED.
2. Submit a separate form for each individual whose name is to be searched.
3. Provide proof of identify and sign Part III in the presence of a Notary Public.
4. This form must be notarized.
5. Return the completed form to either:

Local Department of Social Services in the area where you reside  
 or  
 Department of Human Resources  
 In-Home Services  
 Social Services Administration  
 311 W. Saratoga Street, Room 553  
 Baltimore, MD 21201

**Part I: PURPOSE OF SEARCH:** (Complete below and the person that this search pertains to must sign the form on the reverse in part III.)

**A. RELEASE TO SELF:**

- 1. To determine if I have been found responsible for indicated or unsubstantiated disposition for a child abuse or neglect investigation.
- 2. To determine if I have any remaining appeal rights

**B. RELEASE TO AN AGENCY/INDIVIDUAL RELATED TO:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Foster Parent                    | <input type="checkbox"/> School Personnel       | <input type="checkbox"/> Day Care Center                  |
| <input checked="" type="checkbox"/> Kinship Care Provider | <input type="checkbox"/> Institutional Employee | <input type="checkbox"/> Family Day Care Provider         |
| <input type="checkbox"/> Adoptive Parent                  | <input type="checkbox"/> CASA                   | <input type="checkbox"/> Other Employment (Explain _____) |
| <input type="checkbox"/> Custody Evaluation               | <input type="checkbox"/> Volunteer              | <input type="checkbox"/> Other (Explain _____)            |

1. Requesting Agency Or Individual Name <b>Child and Family Services Agency</b>	2. Name Of Agency Representative <b>Robert Matthews, Program Manager</b>
3. Address <b>200 I Street, SE</b>	City <b>Washington</b>
	State <b>DC</b>
	Zip <b>20003</b>
	Telephone <b>202-724-8943</b>

**C. RELEASE OF SUMMARY OF AGENCY FINDING:**

I am aware that I have an indicated disposition following a child abuse or neglect investigation and I authorize the agency to release a summary to the individual/agency identified in part I as to why I was found responsible.

**Part II: TO BE COMPLETED IN FULL, BY INDIVIDUAL WHOSE NAME IS BEING SEARCHED**

	Last Name	First	Full Middle	Maiden/Birth Name
<b>1. IDENTIFYING INFORMATION:</b>	Social Security #	Race	Sex	Birthdate
				Other Names Used
<b>2. CURRENT ADDRESS</b>		City	State	Zip
<b>3. PRIOR ADDRESS(S) AND DATE(S) (Within The Past 7 Years)</b>		City	State	Zip
		City	State	Zip
<b>4. CURRENT SPOUSE</b>	Last, First, Full Middle		Race	Sex
				Birth Date
<b>5. PREVIOUS SPOUSE</b>	Last, First, Full Middle		Race	Sex
				Birth Date
<b>6. FULL NAMES OF ALL CHILDREN LIVING WITH YOU (Also include adult children not living with you. Attach additional paper if needed)</b>	Last, First, Full Middle		Race	Sex
				Birth Date

**Part III: AUTHORIZATION** (Check either 1 or 2 below. )

Pursuant to Maryland Code of Regulation Section 07.02.07.19, pertaining to the confidentiality of Child Protective Services records and reports, I hereby authorize the Maryland Department of Human Resources (DHR):

- 1. To notify \_\_\_\_\_ (self, agency, or individual listed in part I) as to whether a local department of social services has identified me as responsible for "indicated" child abuse or neglect in any record maintained by the Maryland DHR, any Local Department of Social Services, and Child Protective Services.
- 2. To release a summary of the indicated finding to CESA \_\_\_\_\_ (self, agency, or individual listed in part I).

**SIGNATURE:** This form must sign in the presence of a Notary Public by the person named in part II.

DATE: \_\_\_\_\_

**Part IV. CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL BEFORE A NOTARY PUBLIC**

City/County of: \_\_\_\_\_ State of: \_\_\_\_\_

Acknowledged before me this \_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_

**Part V. BACKGROUND CLEARANCE FINDINGS** (for Local Department or DHR use only)

- 1. We are unable to determine at this time if the individual for whom a search has been requested has a CPS finding. Form returned to requesting agency. Date \_\_\_\_\_
- 2. Sent to DHR or Local Department of Social Services: Name \_\_\_\_\_  
Date \_\_\_\_\_  
Date returned from Local Department \_\_\_\_\_
- 3. Based on information provided by Local Departments of Social Services, we have determined that \_\_\_\_\_ is listed in the Central Registry as being responsible for an  Indicated/  Unsubstantiated disposition of  Abuse /  Neglect in reference to an investigation conducted in \_\_\_\_\_; Child Protective Service Case/File/Referral #: \_\_\_\_\_
- 4. Holding for Appeal Appeal Date \_\_\_\_\_ Appeal Disposition \_\_\_\_\_
- 5. Notification sent to Requesting Agency/Individual: Date \_\_\_\_\_
- 6. Notification sent to Person: Date \_\_\_\_\_
- 7. Summary Provided: Date \_\_\_\_\_
- 8. As of this date, the individual whose name was being searched is NOT identified in the Central Registry as being responsible for abuse or neglect.

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



**Pre-Service Training Requirements for Temporary Kinship Foster Parents**

I, \_\_\_\_\_  
Applicant 1 Applicant 2

understand and agree that I am required by Policy & Regulation to attend Child and Family Services Agency's (CFSA's) five (5) week pre-service training session for Foster Kinship/Adoptive parents.

I understand that my spouse or paramour or significant other is also required to attend this five (5) week Pre-Service Training.

I understand that these classes are held primarily during the evening hours and I must make the appropriate accommodations for attendance.

I understand and agree that after I get my approved Emergency Temporary License that I must call Tamara Smith- Jackson, Staff Assistant, at 202-727-3893 within four (4) days and schedule for the next available set of Pre-Service MAPP/Pre-Service Training Classes. No exceptions are made for working or taking classes in the evening.

I understand and agree that if I cannot take these training sessions a temporary license will not be granted to me.

I understand that if I fail to attend these classes after the child is placed, the child will be removed and an alternative placement for the child will be sought.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Worker's Signature

\_\_\_\_\_  
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



LEAD INFORMATION

*This request is only necessary for the placement of children under the age of (6) years old.*

Name of Potential Provider:

\_\_\_\_\_

Address of Potential Provider:

\_\_\_\_\_

Contact Numbers of Potential Provider:

\_\_\_\_\_

Please check appropriate box:

Home Built before 1978: \_\_\_\_\_ home Built after 1978: \_\_\_\_\_

**PLEASE READ:** If the home requesting emergency placement was built before 1978 and a child under the age of (6) years old is in need of placement, a lead inspection must be conducted and the home must be found to be lead free before an emergency temporary license can be granted and placement can occur.

If the home requesting emergency placement was built before 1978 and **has not** been previously inspected /cleared for lead then a lead inspection request will be submitted on behalf of the provider **by our office** upon submission of this packet. An inspector from DDOE will make contact with provider to schedule an inspection.

If the home requesting emergency placement was built before 1978 and has **previously** been cleared of existing lead then the potential provider **must provide** along with this packet, a cleared lead inspection, (not Lead Disclosure)

If the home requesting emergency placement was built **after** 1978, the potential provider **must submit proof of the year** the home was built upon submission of this packet for review.

\_\_\_\_\_  
Simone Z. Sibert  
Lead Base Paint Specialist  
202-727-7318 Office

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
 Child and Family Services Agency



**ASSESSMENT TOOL FOR PLACEMENT OF CHILDREN IN KINSHIP HOME**

Date of Evaluation \_\_\_\_\_

Prospective Kinship: **Provider 1** \_\_\_\_\_  
 Last First Date of Birth

**Provider 2** \_\_\_\_\_  
 Last First Date of Birth

Social Security Number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Provider 1 Provider 2

Complete Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_  
 Provider 1

Provider 2

List other occupant(s) in the home besides potential providers	Age	Date of Birth	Sex	Relationship to provider(s)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Names of Children to be placed	Age	Date of Birth	Sex	Relationship to provider (s)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of Child's Social Worker: \_\_\_\_\_

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

Social Workers Supervisor: \_\_\_\_\_

Supervisors Phone Number: \_\_\_\_\_



Amount of Household Income \_\_\_\_\_

Source of Household Income \_\_\_\_\_

Approximate monthly expenses \_\_\_\_\_

Name and Phone Number of Social Worker performing assessment \_\_\_\_\_

**Please make a selection: must be completed by referring social worker**

**\*\*Indicate with a (X)**

Passed \_\_\_\_\_

Failed \_\_\_\_\_

Reason \_\_\_\_\_

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

Social Workers Signature \_\_\_\_\_

Date \_\_\_\_\_

Supervisor's Signature \_\_\_\_\_

Date \_\_\_\_\_

# NARRATIVE FORMAT GUIDE

## Assessment of Name of Potential Provider Temporary Kinship Foster Home Licensure In the Matter of Name of Child, Child for Placement

### Applicant Information

Applicant Name

DOB:

Address:

IF POTENTIAL PROVIDER'S ARE MARRIED, IN A DOMESTIC RELATIONSHIP OR  
HAVE A LIVE-IN SIGNIFICANT OTHER, THE ASSESSMENT SHOULD REFLECT THE  
COUPLE

### Interview and Description:

- Name of applicant(s)
- Name and age of child
- Case Number
- Date of assessment
- Purpose of assessment
- Attendees at assessment interview

### Background Information:

- Relationship of the potential provider to the family and child
- Basic family information
- Household members, names, and ages
- Employment Information to include work hours (back up provider if needed)
- Monthly Income
- Monthly Expenses
- Statement reflecting potential provider is able to meet needs independently of subsidy

### Clearances:

- Any prior criminal history CFSA should be aware of (include probation)
- Statement regarding the outcome of clearances or discussion that potential provider can not be licensed until clearances are received.

### Home and Community:

- Type of home
- Length of years residing in home
- Observation of the appearance of the home
- Detailed explanation of sleeping arrangements for all household members, to include room measurements, room furnishings, and appropriateness for a

## NARRATIVE FORMAT GUIDE

**placement of a child. Please include statement of where ALL members are sleeping and if beds are in the home**

- Safety features (fire extinguisher, smoke detectors)
- Statement if Lead inspection is needed
- Observation of the community

### Interview

- Review of roles and responsibilities of foster parent
- Knowledge of why placement child was removed from home
- How they will ensure that placement child is safe from future harm
- Medical History
- Child rearing techniques
- Discipline techniques, statement reflecting that techniques are appropriate
- Strengths and Needs
- Support system
- Potential providers understanding of permanency goal, services needed for placement child, and visitation schedule
- Potential providers level of cooperation and understanding of full kinship licensure requirements to include foster parent training

### Assessment

- Statement regarding potential provider's demeanor
- Justification of why potential provider is an appropriate placement resource

### Recommendations

- Social workers recommendation for licensure

---

Social Worker Name and Credentials  
Title  
Division/Unit  
Office Number  
Cell Number

---

DATE

---

Supervisors Name and Credentials  
Title  
Division/Unit  
Office Number  
Cell Number

---

DATE

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
Child and Family Services Agency



To: Kinship/Traditional/Adoptive Foster Parent Applicants  
Re.: Fire Inspection Regulations

The Child and Family Services Agency is grateful for your willingness to open your homes and your hearts to the children of the District of Columbia, whose lives have been touched by child abuse and neglect. The task to care for the needs of the children is a daunting one and your graciousness in partnering with us to meet this need is heart-felt and appreciated. The agency is well aware that we cannot do the work we do without you.

The Family Licensing and Training Division is the licensing arm of the Child and Family Services Agency. We work communally with you and other local District Government agencies to license homes that meet the District of Columbia Municipal Regulations (DCMR), as it relates to fire inspections. According to the DCMR Chapter 60, it states:

**29-6007. GENERAL PHYSICAL ENVIRONMENT**

6007.1 A foster home shall be free from all safety hazards, including fire, sanitation, and health hazards.

6007.28 A foster parent who lives in an apartment building shall obtain evidence from the building manager or landlord that the building has been approved for fire safety within the last two (2) years.

Each home must complete and successfully pass a fire inspection and meet with the District regulations in this and other areas. As of January 1, 2009, the fee for fire inspections is \$150.00 per home. We are working in partnership with the DC Fire Department to establish an agreement that will serve to meet the needs of the agency and promote compliance with the fire inspection regulations, to include inspections of all adoptive/traditional/kinship homes and those residences located within apartment buildings. Until such time as we have been able to establish this agreement, the fee for fire inspections of all foster/adoptive/kinship homes and apartment buildings shall be held in abeyance until further notice.

We appreciate your attention to this matter and will keep you informed each step along the way. Again, thank you for your support and patience as we move forward to a successful agreement.

Sincerely,

  
Robert Matthews, Program Manager  
Child and Family Services Agency  
Kinship Family Licensing Unit  
Office of Entry Services

# **FIRE INSPECTIONS**



**Office of the Fire Marshal  
District of Columbia Fire and EMS Department  
Waterfront Complex  
1100 4<sup>th</sup> Street, SW  
Suite E-700  
Washington, DC 20024  
202-727-1600**