

Laurel Heights Hospital Application for Specialized Foster Care Parent

Name of Applicant(s)		Street Address			
City		Zip Code	How long at this address:	Today's date:	
County		Referred by:			
Home phone:	Work phone:		Work phone:		
Work hours for parent(s):					
High school diploma/GED? Yes <input type="checkbox"/> No <input type="checkbox"/>		At least 21 years old? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Georgia driver's license? Yes <input type="checkbox"/> No <input type="checkbox"/> (Attach Copy)		Insurance on car? Yes <input type="checkbox"/> No <input type="checkbox"/> (Attach Copy)			
Reliable transportation? Yes <input type="checkbox"/> No <input type="checkbox"/>		MAPP/IMPACT Trained? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Previous experience with children? Yes <input type="checkbox"/> No <input type="checkbox"/>		Describe:			
Age preferred?	Gender preferred?		Race preferred?		
Approximately how many miles is your home from Laurel Heights?					
List all people living in your home, including yourself					
Name		Sex	Race	Date of Birth/Age	Relationship
Housing Information					
Rent <input type="checkbox"/> Own <input type="checkbox"/>	House <input type="checkbox"/> Apt <input type="checkbox"/>	# of Bedrooms:		Total # of rooms:	
Have you fostered/adopted in the past? Yes <input type="checkbox"/> No <input type="checkbox"/> (Please note that we will ask you to sign a release of information for a reference from this agency.)		If yes, when?		For what agency?	
Have you applied to other agencies? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, when?		What agency?	

What is your motivation for becoming a Specialized Foster Care Parent?

Please list 2 **relatives** (1 from each side of family, if applicable) in close contact with your family:

Name: _____ Daytime Phone #: _____
Address: _____

Name: _____ Daytime Phone #: _____
Address: _____

Please list 3 **non-relative** references who have known you well for a period of years (friend, neighbor, clergy, etc.):

Name: _____ Daytime Phone #: _____
Address: _____

Name: _____ Daytime Phone #: _____
Address: _____

Name: _____ Daytime Phone #: _____
Address: _____
/

We have received and reviewed written orientation information about LH SFC Program. We understand that, by making this application, there is no definite commitment by us or by Laurel Heights Hospital.

Applicant's Signature: _____

Applicant's Signature: _____

When completed, please return to:

Laurel Heights Specialized Foster Care
934 Briarcliff Road, N.E.
Atlanta, Georgia 30306
404-888-6040