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|  | LICENSING DIVISION (LD)**File Checklist (Kinship License)** |
| APPLICANT / PROVIDER NAME | PROVIDER NUMBER |
| ADDRESS | CITY | STATE**, WA** | ZIP CODE |
| **I have verified the following requirements:** |
| TB screening (including negative TB test or documentation from a licensed medical provider where indicated) for all adults in home. | Yes [ ] N/A [ ] Waiver [ ] Non-Safety Exemption [ ]  |
| Vaccine Exemption (DCYF 15-455) verified for all child household members needing a vaccine exemption. | Yes [ ] N/A [ ] Waiver [ ] Non-Safety Exemption [ ]  |
| Pertussis vaccine (per agreement) and/or Vaccine Exemption (DCYF 15-455) verified for all adult household members (if caring for children under the age of 2 years or medically fragile children). | Yes [ ] N/A [ ] Waiver [ ] Non-Safety Exemption [ ]  |
| Influenza vaccine (per agreement) and/or Vaccine Exemption (DCYF 15-455) verified for all household members. | Yes [ ] N/A [ ] Waiver [ ] Non-Safety Exemption [ ]  |
| Cleared well test for private water. | Yes [ ] N/A [ ] Waiver [ ] Non-Safety Exemption [ ] Compliance Agreement [ ]  |
| This home meets the ICWA/WICWA definition of an Indian Foster Home (verification uploaded). | Yes [ ] N/A [ ]  |
| All applicants were provided an opportunity to review the Notice of Nondiscrimination publication (HR\_0012). | Yes [ ] Other [ ]  **\_\_\_\_\_** |
| Background check completed for all household members ages 16 & 17.  | Yes [ ] N/A [ ]   |
| FamLink check completed for all household members under the age of 18.  | Yes [ ] N/A [ ]   |
| Open investigations. | None [ ] Other [ ]  **\_\_\_\_\_** |
| Pending Compliance Agreements (DCYF 10-248) | None [ ] Provider agrees to sign a Compliance Agreement related to [ ]  **\_\_\_\_\_** |
| This home study includes adoption. | Yes [ ] No [ ] N/A [ ]  |
| **I have verified the following adoption requirements:** |
| Marriage and/or divorce decrees and/or death certificates. | Yes [ ] N/A [ ]  |
| Income verification. | Yes [ ] N/A [ ]  |
| Applicant Medical Report (DCYF 13-001) completed by medical provider. | Yes [ ] N/A [ ]  |
| **Additional Comments** |

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| **LD/CPA Staff Signatures** |
| LD/CPA STAFF NAME | LD/CPA SUPERVISOR NAME |
| LD/CPA STAFF SIGNATURE DATE | LD/CPA SUPERVISOR SIGNATURE DATE |