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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | LICENSING DIVISION (LD)**Application for Certified Respite Provider****[ ]  State** **[ ]  CPA**  |

**The care is to be provided only in a licensed foster home.** |
| **Applicant Information** |
| **NAME****(IF ANY)****(LIST IN FULL)** | FIRST NAME | MIDDLE NAME (IF ANY) | LAST NAME | SUFFIX |
| **PREFERRED NAME (IF ANY)****(LIST IN FULL)** | FIRST NAME | MIDDLE NAME (IF ANY) | LAST NAME | SUFFIX |
| **FORMER NAMES,****NICKNAMES,****OTHER NAMES YOU HAVE GONE BY** **(IF ANY)****(LIST IN FULL)** | FIRST NAME | MIDDLE NAME (IF ANY) | LAST NAME | SUFFIX |
| FIRST NAME | MIDDLE NAME (IF ANY) | LAST NAME | SUFFIX |
| FIRST NAME | MIDDLE NAME (IF ANY) | LAST NAME | SUFFIX |
| **WHAT IS YOUR:** | GENDER IDENTITY[ ]  Female [ ] Male [ ]  X | BIRTHDATE | SOCIAL SECURITY NUMBER |
| PHONE NUMBER | EMAIL | PREFERRED CONTACT[ ]  Phone [ ] Text [ ]  Email [ ] Postal Mail |
| **STREET ADDRESS** | STREET ADDRESS | CITY STATE**,** | ZIP CODE (+4 OPTIONAL) | COUNTY |
| **MAILING ADDRESS****(IF DIFFERENT)** | STREET ADDRESS | CITY STATE**,** | ZIP CODE (+4 OPTIONAL) | COUNTY |
| **LANGUAGES IN WHICH YOU CAN COMMUNICATE WITH A CHILD** | PRIMARY | ADDITIONAL |
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| **Type of Care** |
| Once you are certified as a respite provider, you are approved to provide support in any licensed foster home. I am willing to provide respite support to: [ ]  General foster homes [ ]  A specific home [ ]  Both |
| NAME OF SPECIFIC FOSTER HOME WHERE YOU WILL PROVIDE RESPITE CARE (IF APPLICABLE) |
| STREET ADDRESS | CITY , WA | ZIP CODE (+4 OPTIONAL)  | COUNTY  |

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| **Background** |
| Have you ever been told that you have a problem with any of the following: (pick all that apply) [ ]  Alcohol (Please Describe):  [ ]  Marijuana (Please Describe):  [ ]  Illegal drugs (Please Describe):  [ ]  Mental Health (Please Describe):  [ ]  Prescription drugs (Please Describe):  [ ]  Anger management (Please Describe):  [ ]  N/A [ ]  Prefer to discuss in person Have you had a serious injury, illness, or hospitalization during the past year? (pick one) [ ]  Yes (Please Describe):  [ ]  No [ ]  Prefer to discuss in person  Have you had a history of mental or physical limitations? (pick one) [ ]  Yes (Please Describe):  [ ]  No [ ]  Prefer to discuss in person Are you currently taking medication that will affect your ability to care for a child? (pick one) [ ]  Yes (Please Describe):  [ ]  No [ ]  Prefer to discuss in person  |
|  |
| **Character References** |
| NAME(FIRST AND LAST) | EMAIL | TELEPHONE NUMBER(INCLUDE AREA CODE) | RELATIONSHIPTO APPLICANT | MAILING ADDRESSINCLUDING ZIP CODE(IF NO EMAIL ADDRESS) |
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| I give permission to DCYF to contact references listed in this application and to discuss issues relevant to my application.I understand that DCYF will do a criminal history record check and a check for files regarding abuse and neglect.I certify that the above information and required attachments are true and complete to the best of my knowledge.I understand that failure to truthfully disclose all relevant information may be grounds for denial of this Application for Certified Respite Provider. |
| SIGNATURE | DATE |