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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 | | | | |
|  | | | | | | | |
| **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) | RELATIONSHIP  TO APPLICANT | MAILING ADDRESS  INCLUDING ZIP CODE  (IF NO EMAIL ADDRESS) |
|  |  |  |  |  |
|  |  |  |  |  |
| 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 |