|  |  |
| --- | --- |
| Worker Name and Agency: | Child(ren)’s Name: |
| Date Home Study Conducted: | Court Case No: |

**SECTION I: CONTACT INFORMATION**

|  |  |
| --- | --- |
| **Contact/Identifying Information** | |
| Caregiver 1: | Caregiver 2: |
| Relationship to Child(ren): | Relationship to Child(ren): |
| Date Moved into Current Address: | Date Moved into Current Address: |
| Address: | Address: |
| City: | City: |
| County, State & Zip Code: | County, State & Zip Code: |
| Home Phone: | Home Phone: |
| Cell Phone: | Cell Phone: |

**SECTION II: HOUSEHOLD MEMBERS and BACKGROUND/QUALIFICATIONS**

**A, Household Members (Other than Caregivers noted above):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Do NOT document Social Security Numbers on this form; record elsewhere in FSFN.** | | | | | | |
| Name of Household Member | Relationship to Caregiver | Date of Birth/Age | Social Security # Verified | Race | Gender | Primary Language Spoken |
|  |  |  | Yes  No |  |  |  |
|  |  |  | Yes No |  |  |  |
|  |  |  | Yes No |  |  |  |

**B. Background checks:**

**Criminal Record and Child Abuse records have been checked for household members living in the home as required.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Relationship to Caregiver** | **Social Security # Verified** | **Local Background** | **FSFN** | **NCIC**  **(Fingerprints and FDLE)** | **Cleared** | **Reason for Disqualification** |
|  |  | Yes  No | Y  N  Date: | Y  N  Date: | Y  N  Date: | Y  N |  |
|  |  | Yes  No | Y  N  Date: | Y  N  Date: | Y  N  Date: | Y  N |  |
|  |  | Yes  No | Y  N  Date: | Y  N  Date: | Y  N  Date: | Y  N |  |

**C. Clearance Issues:**

**SECTION III: ASSESSMENT OF HOME AND PHYSICAL ENVIRONMENT**

|  |  |  |
| --- | --- | --- |
| 1. Rent or Own (circle one) Landlord name: Landlord phone: | | |
| 2. General Description of Home (including number of rooms and number of bedrooms): | | |
| 3. General Description of Neighborhood: | | |
| 4. Date Sex Offender Neighborhood Check (1 mile radius of home) was completed, and results: | | |
| 5. Name of Schools the Children will Attend:  6. Method of Child’s Transportation to School (walk, bus, bike, car; indicate who will drive child): | | |
| **The new residence:** | **For each item, indicate “Yes,” or “No” and provide a brief explanation** | |
| 7. Is adequately furnished. | Yes No |  |
| 8. Will provide each child with adequate and appropriate sleeping arrangements (every child in own bed/crib; no child in bed w/adult). | Yes No |  |
| 9. Has no visible hazardous conditions which would be hazardous to child health and safety. | Yes No |  |
| 10. Has a pool or is near water, and/or the caregiver has been counseled on water safety, or safety measures. Ensure Water Safety Addendum is reviewed and signed. | Yes No |  |
| 11. Has reasonable security measures. Ensure Fire Arm Safety Requirements Form is reviewed and signed. | Yes No |  |
| 12. Has medicines, alcohol, cleaning agents out of reach of children. | Yes No |  |
| 13. Has working smoke/fire alarm. | Yes No |  |

**Section IV. FINANCIAL ARRANGEMENTS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Caregiver 1**  **Name:** | | | **Caregiver 2**  **Name:** | | | **Household** | |
| 1. Current Employer |  | | |  | | | 7. Combined Monthly | $ |
| 2. Employer’s Address |  | | |  | | | Income |
|  |  | | |  | | | 8. Expenses |  |
| 3. Length of Current Employment |  | | |  | | | * Housing | $ |
| 4. Hours and Shifts Worked |  | | |  | | | * Utilities | $ |
| 5. Gross Monthly Salary | $ |  | | $ |  | | * Transportation | $ |
| (if paid weekly or bi-weekly, calculate into monthly amount) |  |  | |  |  | | * Food/Supplies | $ |
| 6. Additional Support or Income |  | | |  | | | * Medical | $ |
| * Social Security Benefits | $ |  | | $ |  | | * Child Care | $ |
| * Retirement Benefits | $ |  | | $ |  | | * Car Payment * Car Insurance * Other Bills (list below) | $ |
| * Temporary Cash Assistance | $ |  | | $ |  | | Cable/Internet | $ |
| * Food Stamps | $ |  | | $ |  | | Cell Phone | $ |
| * Disability Benefits | $ |  | | $ |  | |  | $ |
| Other | $ |  | | $ |  | |  | $ |
|  | $ |  | | $ |  | |  | $ |
| Total | $ |  |  | $ |  |  | Total Monthly Expenses | $ |

|  |
| --- |
|  |
| 1. Does the caregiver(s) have sufficient funds to support the current expenses?  Yes  No, explain: |
| 1. What new expenses are anticipated for the child(ren) in the home? |
| 1. What additional services will be needed in order to help ensure placement stability? (List all): |

**Caregiver Attestation and Acknowledgement**

**To the best of my knowledge, I have given truthful information on all questions asked of me.**

**In addition, I acknowledge receipt of the following (check all that apply):**

Water Safety Advisory   Firearms Safety  Sudden Infant Death Syndrome and Ways to Help Prevent It

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

Printed Name Signature Date

Caregiver #1 Caregiver #1

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

Printed Name Signature Date

Caregiver #2 Caregiver #2

**AGENCY APPROVAL/DENIAL/RECOMMENDATIONS**

**Family Name:**

Based upon all materials submitted, interviews held, observations made during the home study process, review of all references and background clearances, it is the agency’s that the following course of action be taken on this placement/license:

Approved:

Denied:

DENIAL: State reasons for denial or non-approval. The reasons must be documented in the home study (address concerns.) Be specific as to the conditions needing

improvement and the services directed at each of these conditions. Include a date and a process for evaluation of the improvement plan.

Approval/Denial is DEFERRED pending the caregiver’s decision whether to proceed with an improvement plan to overcome the conditions and utilize the

identified services, as provided in attached supporting documentation.

**SIGNATURES ARE REQUIRED OF THE PERSONS COMPLETING AND APPROVING THE HOMESTUDY**

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

Signature Date Signature Date

Case Manager Case Manager Supervisor

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

Signature Date

Assistant Program Director