



CHILDREN'S ADMINISTRATION
DIVISION OF LICENSED RESOURCES

Application For Respite Provider Approval
care to be provided only in licensed foster home

NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS				CITY	STATE ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				CITY	STATE ZIP CODE
WORK TELEPHONE NUMBER	HOME TELEPHONE NUMBER	CELL PHONE NUMBER	E-MAIL ADDRESS		
NAME OF FOSTER HOME WHERE YOU WILL PROVIDE RESPITE CARE (IF KNOWN)					
ADDRESS				CITY	STATE ZIP CODE
I am available to do respite care in other licensed foster homes. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Yes	No	Have you:			
<input type="checkbox"/>	<input type="checkbox"/>	A. Had a serious injury, illness or hospitalization during the past year, or a history of mental or physical limitations?			
<input type="checkbox"/>	<input type="checkbox"/>	B. Are you currently taking medication? If yes, please list:			
<input type="checkbox"/>	<input type="checkbox"/>	C. Been found to be perpetrator of child abuse?			
<input type="checkbox"/>	<input type="checkbox"/>	D. Engaged in the illegal use or sale of drugs?			
<input type="checkbox"/>	<input type="checkbox"/>	E. Been told you have a problem with alcohol?			
CHARACTER REFERENCES - No more than one reference can be related to you.					
NAME (FIRST AND LAST)		ADDRESS (INCLUDE ZIP CODE)		RELATIONSHIP TO APPLICANT	TELEPHONE NUMBER (INCLUDE AREA CODE)
<p>I give permission to DSHS/Private Agencies to contact references listed in this application and to discuss issues relevant to my application.</p> <p>I understand that DSHS will do a criminal history record check and a check for files regarding abuse and neglect.</p> <p>I certify that the above information and required attachments are true and complete to the best of my knowledge.</p> <p>I understand that failure to truthfully disclose all relevant information may be grounds for denial of this application for respite provider.</p>					
SIGNATURE					DATE