

Application for MCCC Foster Care, Therapeutic Foster Care, and Adoption Services Program		1. License Control ID NO.	2. Date Application Received	
		3. Foster Care/Adoption Service Case Number		
4. Type of Application: Check all that apply <input type="checkbox"/> New-Foster Care <input type="checkbox"/> Renewal-Foster Care <input type="checkbox"/> Moved New License <input type="checkbox"/> Adoption				
5. APPLICANT NUMBER 1		6. APPLICANT NUMBER 2		
NAME (LAST, FIRST, MIDDLE)		NAME (LAST, FIRST, MIDDLE)		
MAIDEN NAME (Also list former married name(s) if applicable)		MAIDEN NAME (Also list former married name(s) if applicable)		
OCCUPATION		OCCUPATION		
EDUCATION (Highest Grade Completed)	YEARLY INCOME (Gross)	EDUCATION (Highest Grade Completed)	YEARLY INCOME (Gross)	
GENDER		GENDER		
7. STREET ADDRESS				
		CITY	STATE	ZIP CODE
8. MAILING ADDRESS				
		CITY	STATE	ZIP CODE
9. TELEPHONE NUMBERS (Include Area Code) WORK: _____ HOME: _____ CELL: _____ E-MAIL ADDRESS: _____		10. PLACEMENT PREFERENCE <input type="checkbox"/> No Preference OR: Number _____ From Age _____ Up to _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either		
11. NAMES OF NEAREST SCHOOLS				
Elementary		Middle/Jr. High School		High School
12. PERSONS LIVING IN HOUSEHOLD (INCLUDING SELF) ATTACH ADDITIONAL SHEET IF NEEDED				
NAME (FIRST/LAST)	DOB	M/F	RELATION TO APPLICANT(S)	SSN
1.				
2.				
3.				
4.				
5.				
6.				
7.				
13. Are there other persons living on your property? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. Character References (no more than one reference can be related to you)				
NAME (First and Last)	COMPLETE ADDRESS (Including Zip Code)	RELATIONSHIP TO APPLICANT(S)	TELEPHONE NUMBER (Including Area Code)	

PLEASE ANSWER THE FOLLOWING QUESTIONS

15. Have you resided in the state of Kentucky consecutively for the past 5 years? Yes No
 If no, please list all previous addresses for each applicant for the last 5 years. Add more sheets if needed.

NAME	CITY	COUNTY AND STATE	DATES: TO - FROM

16. For those in the household who drive:	Applicant #1		Applicant #2		Other	
	Yes	No	Yes	No	Yes	No
A. Do you have a valid driver's license?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Are there any restrictions on your license? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Do you have automobile liability/medical insurance? (Please attach a current copy showing amounts of coverage and expiration date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has applicant or any other member of the household:						
A. Had a serious injury, illness or hospitalization during the past year, or currently taking medication or have a history of mental or physical limitations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Been found to be a perpetrator of child abuse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Engaged in the illegal use or sale of drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been told that they have a problem with alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been denied a license to care for children or adults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Had a license to care for children or adults suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Ever applied for a home license before? Where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Have you applied to adopt a child before? Where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Emergency Contact Information

In State/Out of Area			Out of State		
NAME			NAME		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE		HOME PHONE	CELL PHONE	
WORK PHONE			WORK PHONE		

We/I further certify that the above information and required attachments are true and complete to the best of my (our) knowledge. Failure to truthfully disclose all relevant information may be grounds for denial of this application or revocation of a license.

We/I give permission for MCCC Foster Care and Adoption Services to contact references listed in this application **and** to discuss issues relevant to my (our) application for foster care license and/or adoption services.

We/I understand that MCCC will do a criminal history record check and a check of DCBS files (CAN'S Check) of abuse and neglect for all persons applying.

APPLICANT 1 SIGNATURE _____ DATE _____

APPLICANT 2 SIGNATURE _____ DATE _____

NOTE: Mountain Comprehensive Care Center, Inc. Private Child Foster Care and Adoption Services may deny suspend, revoke, or not renew a license for misrepresentation or material omissions on this application.