If the foster parent's last name begins with A through I then your contact is **Kris Garcia** at kgarcia@divinityfamilyservices.com

If the foster parent's last name begins with J through R then your contact is **Kim Sarro** at ksarro@divinityfamilyservices.com

If the foster parent's last name begins with S through Z then your contact is **Diana Yanez** at dyanez@divinityfamilyservices.com and all Spanish Speaking Families

1. Please begin by completing the DFS Consent for Background Check (everyone in the home over 14 years of age, excluding foster children) forms and Authorization for Release of Information. Please send the forms and a copy of TDL/State ID *AND* your social security card to accompany each DFS consent via email. Once we submit your background checks we will send you the fingerprinting appointment instructions.
   *Please email TDL/State ID cards/social security cards. Faxed copies of TDL/State ID card/social security cards will not be legible.
   *Please do not have your fingerprinting completed at the Sherriff's Department.
2. Complete the DFS Application.
3. Complete Health Status Questionnaires for everyone in your home. (excluding foster children)
4. Complete DFS Communication Plan and DFS Direct Deposit Form.
5. Collect and send other required documents.
   -Auto insurance
   -Home owner's/renter's insurance
   *not a requirement
   -All pet's rabies vaccinations
   -Current marriage license
   -All divorce decrees
   -GED certificate(s)/high school diploma(s)/college diploma(s)
   -Most recent tax return

-Family Income

*Two full months of paycheck stubs for each employed foster parent

*Retirement income

*All benefit award letters for government assistance

(TANF, WIC, SNAP/Food stamps, SSI, RSDI)

*Child Support

-Floor plan of your home

Please include:

*placement of windows and doors

*dimensions of each room

*where everyone in the home is sleeping

6. Complete TDFPS Online Trainings
   - Psychotropic Medication Training
   -Medical Consenter Training
   -Trauma Informed Care Training

7. Have TB testing completed and submitted on everyone in the home (over one year of age) within 30 days of your licensure being approved for licensure.

8. Complete a CPR/First Aid Course

*Must be in person and not an online course and must cover adult, child and infant

*Divinity Family Services does offer a course at a discounted rate. Please check with your assigned worker to see when the next class is offered.

9. Fire Inspection and Environmental/Health Inspection
   -Divinity Family Services will complete your fire and health inspection during our visits to your home. These inspections are offered free of charge.
   -In order to pass these inspections please ensure that you have a 5lb RED fire extinguisher on each level of your home. Please submit a receipt of purchase for the extinguisher(s) or a photo of the inspection and service tag.

DFS Consent for Background Investigation

Please return this form with a copy of your Driver's License and Social Security Card

Foster Family Name:_____ **Case Manager for home:**_____

Please circle one: Foster Parent Babysitter Frequent Visitor Household Member over 14 Caregiver

This form is to be completed for any person, age 14 and above, who will be in contact with foster children on a frequent basis (i.e. parents and teenagers living in the home, respite workers, volunteers, foster family member, etc.) You may make additional copies of this form or write on the back for additional people.

1. Full Name (no initials, please) and other names used:

_____ _____ _____
First Name Middle Name Last Name

_____ _____ _____
Other First Name Other Middle Name Other Last Name

2. _____ 3. _____ 4. _____ ID TXDL☐ ☐
Birth date (Mo/Day/Yr) Social Security Number Driver's License Number & State

5. Gender: Male_____ Female_____ 6. Related _____ Unrelated _____
7. Race: White_____ Black _____ Asian/Pacific Islander _____ American Indian _____
8. Ethnicity: Hispanic_____ Non-Hispanic _____ Other_____

9. _____ _____ _____ _____
Street Address (including apt. #) City Zip Code County

_____ _____
EMAIL REQUIRED Phone Number (including area code)

10. Have you lived in another state during the last five years? _____Yes _____No
If yes, please list the state, address, and dates of residency.

State	Address	Dates of Residency (Beginning/Ending Dates)

9. Please list all cities in Texas where you have lived ***at any time throughout your life*** (including dates).

Name of Texas City	Beginning Date	Ending Date

I hereby give my permission for Divinity Family Services to use the above information and/or information included in the DFPS *Form 2971 Request for Background Check* to conduct a background investigation including a criminal history check and FBI finger printing check. All information above is accurate and complete.

_____ _____
Signature of Applicant Date

DFS Consent for Background Investigation

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9. _____ _____ _____ _____
Street Address (including apt. #) City Zip Code County

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I hereby give my permission for Divinity Family Services to use the above information and/or information included in the DFPS *Form 2971 Request for Background Check* to conduct a background investigation including a criminal history check and FBI finger printing check. All information above is accurate and complete.

_____ _____
Signature of Applicant Date

Divinity Family Services

1312 Bandera Hwy Kerrville, TX 78028 (830)-890-5838

Authorization for Release of Information

Have you applied for or been certified as Foster Parents or a Certified Respite Care Provider?

Yes___ No___

If yes, please provide the following information:

I, (we) _____ do hereby authorize:

DIVINITY FAMILY SERVICES
Name and address of entity requested to release information

To release to **Divinity Family Services, Inc.** the contents of my Foster Family File or respite training. This information shall include: Home Studies, Criminal Check and any relevant Risk Evaluation Information, House Floor Plans, Documentation of Initial and all Succeeding Trainings, TB tests, Driver's license/Social security cards, Diplomas, Marriage License, Pet Vaccinations, Fire and Health Inspections, and documentation of any investigations of serious or critical incidents which have occurred in the home. This authorization also includes all verbal communications between anyone releasing the information and the staff at Divinity Family Services. This authorization shall expire within 30 days. I hereby release the licensed child placing agency, its officers and employees providing this information from any claims which might arise from the release of this information.

I also allow Divinity Family Services to share the contents of my background check, Central Registry check and FBI check with those employed with the Texas Department of Family and Protective Services or those individuals associated with any CPS case to which I am involved in.

Signature of Foster Parent / Respite Provider	Date of Birth	Social Security Number
Signature of Foster Parent / Respite Provider	Date of Birth	Social Security Number

Divinity Family Services

HEALTH STATUS QUESTIONNAIRE

(To be completed by each household member)

Name: _____ Date of Birth: _____

MEDICAL HISTORY

Have you had a history of, or treatment for, any of the following?

	No	Yes		No	Yes		No	Yes
Mental/Emotional Conditions			Depression			Stroke		
Cancer			Seizures			Asthma		
Severe Arthritis			Heart Condition			Chronic Headaches		
Chronic Kidney Condition			Tuberculosis			Chronic Fatigue		
Colitis			Ulcers			Insomnia		
Hypertension			High Cholesterol			Thyroid Disease		
Eczema			Hemophilia			Allergies		

Have you ever received treatment for mental health conditions? Yes_____ No_____

If yes, when? _____ From whom? _____

Have you ever been prescribed psychotropic medication for mental or emotional conditions?

Yes _____ No _____

When	Drugs Prescribed

Name: _____Date of Birth: _____

Have you ever participated in counseling for personal or family problems?

Yes _____ No _____

If yes, when, why, and who was the counselor?

_____

_____

Have you ever had a psychological evaluation, or any psychological testing done?

Yes _____ No _____

If yes, when and what was the purpose?

_____

_____

Can you provide a copy of the psychological evaluation/testing report to DFS?

Yes _____ No _____

Have you ever been treated for drug use? Yes _____ No _____

If yes, when, where, and for what drug(s)?

_____

_____

Have you ever been treated for alcoholism? Yes _____ No _____

If yes, when and where were you treated?

_____

_____

If you were treated for drug use and/or alcoholism have you had any relapses since undergoing treatment?

Yes _____ No ____

If yes, please indicate when you relapsed, how you returned to sober living, and how long you've been sober since your relapse.

_____

_____

Name:_____ Date of Birth:_____

List all prescription medications currently being taken on a regular basis.

Medication Name	Reason for Medication

Please give the date of your last visit to the doctor and reason.

_____

Please list all illnesses, surgeries or hospitalizations you have had in the past.

_____

_____

Do you have any physical disabilities? Yes _____ No _____

If yes, what is the disability and when were you diagnosed?

_____

_____

When was your last TB test and what was the result?

_____

A statement may be needed from a physician, psychologist, or counselor concerning you and/or you child's past or current physical, mental, or emotional condition. Are you willing to give permission for the release of such information if necessary?

No _____ Yes _____ _____ _____

Signature Date

Family Communication Plan

Date_____ Region _____

Family Name _____

Primary Care Giver_____

Secondary Care Giver_____

Address_____

_____

City_____State_Texas_____Zip_____

Phone Home (___)_____Cell(___)_____

Other (____)_____

Fill out the following information for each family member and keep it current.

Name (1) _____ Name(2)_____

D.O.B _____ D.O.B _____

S.S#_____ S.S #_____

Important Medical Info_____ Important Medical Info _____

_____ _____

Name(3)_____

D.O.B_____

S.S#_____

Important Medical Info_____

_____

Name(4)_____

D.O.B _____

S.S #_____

Important Medical Info_____

_____

Name(5) _____

D.O.B _____

S.S #_____

Important Medical Info _____

_____

Name(6)_____

D.O.B _____

S.S #_____

Important Medical Info _____

_____

Name(7)_____

D.O.B._____

S.S #_____

Important Medical Info _____

_____

Name(8)_____

D.O.B _____

S.S #_____

Important Medical Info _____

_____

Name(9) _____

D.O.B _____

S.S #_____

Important Medical Info _____

_____

Name(10)_____

D.O.B _____

S.S #_____

Important Medical Info _____

_____

Your family may not be together when disaster strikes, so plan how you will contact one another and review what you will do in different situations.

OUT-OF-TOWN CONTACT NAME: _____

Address_____

City_____ST_____Zip_____

Alt. Telephone Numbers_____

Address_____City_____ST_____Zip_____

Email_____

YOUR FAMILY'S NAME_____

If you plan to stay at a hotel, which city would you be staying in?_____

Where to go in an emergency. Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare, workplaces and apartment buildings all have site-specific emergency plans.

HOME

Address _____

Phone#_____

WORK

Company Name_____

Address_____

Phone #_____

VEHICLE (1)

License Plate # _____

Model _____

Year _____

Color _____

SPECIAL CAREGIVER

Name _____

Phone # _____

VEHICLE (2)

License Plate # _____

Model _____

Year _____

Color _____

SPECIAL CAREGIVER

Name _____

Phone # _____

PETS (1)

Name _____

Breed _____

Weight _____

PET (2)

Name _____

Breed _____

Weight _____

PET (3)

Name _____

Breed _____

Weight _____

Important Information:

Doctor(s) Name, Address and Phone Number:

_____

_____

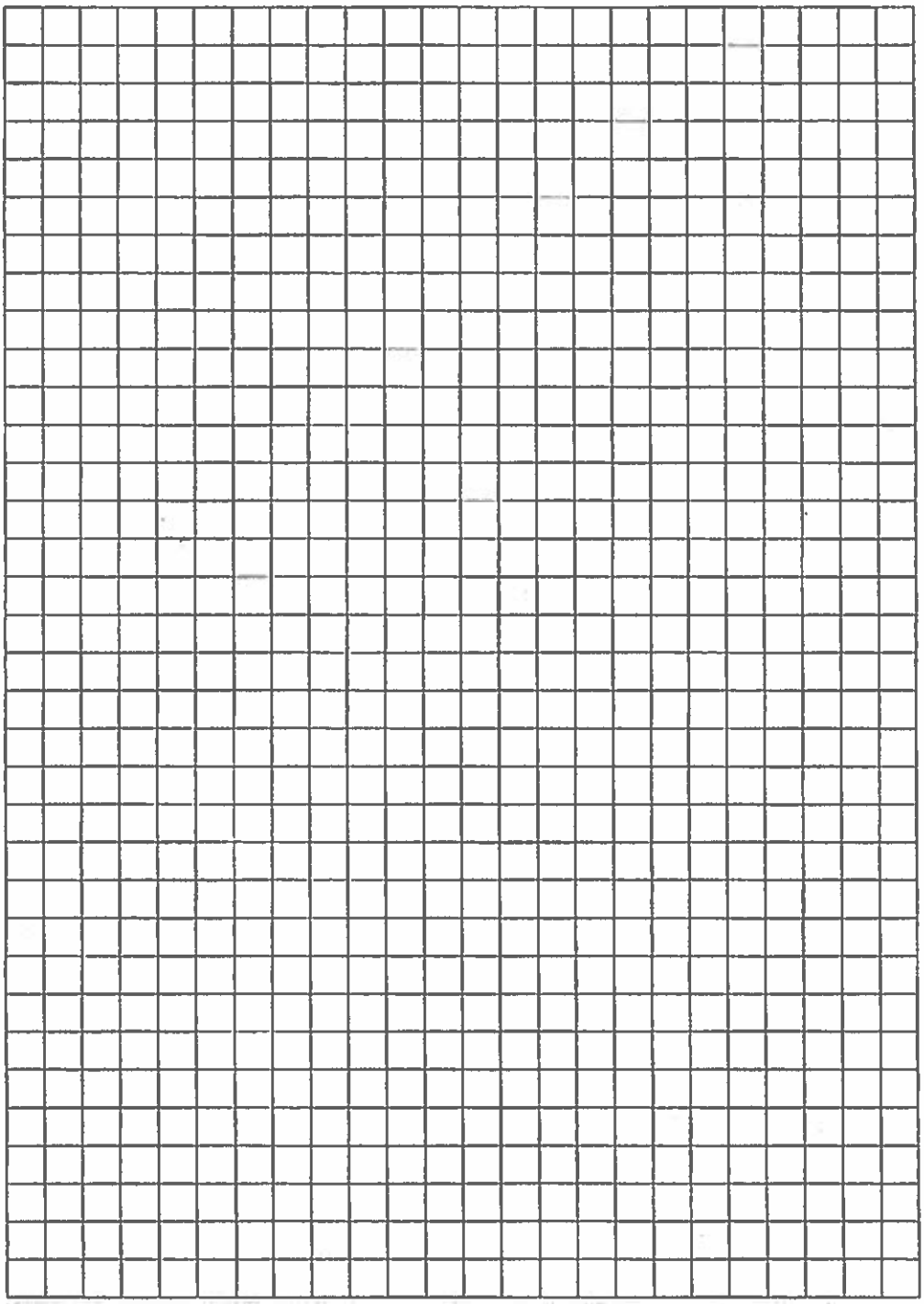
Pharmacist/Pharmacy Address and Phone Number:

_____

Vet/Kennel (Pets) Address and Phone Number:

_____

Evacuation Floor Plan



Please include who sleeps in what room, where windows and doors are located, and dimensions of each room.

Family Name:

Address:

Divinity Family Services' Direct Deposit Authorization

Personal Information	
Full Legal Name on the Account:	Telephone Number:
Address (Street, City, State & Zip):	Email Address:
Financial Institution	
Bank/Credit Union Name:	Account Type: Checking ☐ Savings ☐
Routing Number:	Account Number:
Authorization and Signatures	
I authorize Divinity Family Services to initiate credit and, if necessary, debit entries and adjustments for any credit entries made in error, directly to the aforementioned bank account(s) and to correct any errors occurring from these transactions. In addition, I authorize my financial institution to credit or debit these amounts from my accounts.	
Signature:	Date:

Note: Direct deposit may take up to 14 business days to be approved. In addition, any changes made to your depositing account may take up to 14 days to take affect.

Divinity Family Services Online Trainings

Instructions:

1. Please visit www.dfps.state.tx.us
2. Type the name of the training in the search bar.
3. Upon completion of the training please print a certificate for each person and only one name per certificate.

-Trauma Informed Care Training

https://www.dfps.state.tx.us/training/trauma_informed_care/

-Psychotropic Medication Training

https://www.dfps.state.tx.us/Training/Psychotropic_Medication/

-Medical Consent Training for Caregivers

https://www.dfps.state.tx.us/Child_Protection/Medical_Services/medical-consent-training.asp