Foster Parent Questionnaire

Name of Child(ren): _____ Board #: ___ Return by: ___/___/___

When did the child(ren) come to your home? ___/___/___ How many children are currently in the home? ____ Date of child(ren)'s last physical exam? ___/___/___ Dental Exam: ___/___/___ Eye Exam: ___/___/___			
What is your understanding of why the child(ren) has entered care?	__Physical Abuse __Sexual Abuse __Neglect	__Child's Emotional Problems __Parents Incarceration __Child's Behaviors	__Parents Drug/Alcohol Abuse __Child's Medical/Special Needs __Child's Drug/Alcohol Abuse
Other:			

Services

How much contact do you have with the Case manager? ___Weekly ___Monthly ___None apply ___Other	How much contact does the child(ren) have with the Case manager? ___Daily ___Weekly ___Monthly Most recent date of phone contact? ___/___/___ Most recent date of in-person contact? ___/___/___
How much contact do you have with the child(ren)'s Guardian ad litem (GAL)? ___Every month ___Every six months ___None apply	How much contact does the child(ren) have with the GAL? ___Daily ___Weekly ___Monthly Most recent date of phone contact? ___/___/___ Most recent date of in-person contact? ___/___/___
Do you receive ongoing updates regarding the progress of the child(ren)'s case?	___Yes ___No
Do you feel adequately informed of the child(ren)'s current health and education status?	___Yes, Both ___No, Both ___Health Only ___Education Only
Did you receive enough background information on the child(ren) to meet his/her needs? If no, indicate what would have been helpful.	___Yes ___No Comments:
Is the foster care payment you receive enough to care for the child(ren) and his/her needs?	___Yes ___No
What do you understand the permanency objective of the child(ren) to be?	___Reunification ___Guardianship ___Long-term foster care ___Adoption ___Self-sufficiency ___Independent living ___In transition ___Unknown
Are you willing to keep the child(ren) on a long-term basis should it become necessary?	___Yes ___No ___Too early to tell ___Had not considered at this time Comments:

Have you ,as a foster parent, requested services, and are they being provided

	N/A	Requested	Provided	Provided by/Frequency	Not Provided
Respite Care					
Transportation Assistance					
Clothing Allowance					
Family Support Worker					
Day Care					
Other:					

Please check the following that apply to your foster home:	___Licensed Home ___Approved Home ___Traditional Foster Home ___Agency-based/Therapeutic Foster Home *Agency Name: _____

Visitation

Is visitation occurring with the parents?	Is there sibling visitation?
___Both Parents ___Mom only ___Dad only ___Neither	___Yes ___No ___Some ___N/a
What is the visitation arrangement as you understand it?	
How is the child's behavior prior to and after visits?	

Child's Services

	N/A	Needed, not provided	Provided	Frequency	Completed	Refused	On Waiting List
Alcohol Drug Treatment							
Individual Counseling							
Psychological Evaluation							
Sex Offender Treatment							
Community Treatment Aid							
Family Support Worker							
Support Groups							
Transportation Services							
Family Counseling							
Day Care Services							
Behavior Management							
Special Education							
Educational Assessment							
Physical Therapy							
Play Therapy							
Other:							
Please list any medications the child is taking here:							

Have you had to restrain the child in your home?	___Yes ___No	___Physically ___Chemically	Frequency:_____
What methods were used to calm the child down? Was medical attention needed? If yes, please explain.			
Was the Case manager notified of the restraint? How?	___Yes ___No		

Please include here how the child(ren) is doing in your home and anything else that you would like the Board to know; feel free to add extra pages if you need more room.

Form completed by: _____ Date completed: ___/___/___

THANK YOU, PLEASE RETURN THIS FORM TO:

To respond by taped questionnaire, call 1-800-577-3272