

Minnesota Adoption and Child Foster Care Application

Instructions

To apply for a child foster care license and/or adoption home study, complete and send this form along with the [Minnesota Adoption and Foster Care Individual Fact Sheet \(DHS-4258B\)](#) for each applicant to your local county social service agency or a private child-placing agency.

LICENSING AGENCY	
TYPE OF APPLICATION <input type="radio"/> New application <input type="radio"/> Update <input type="radio"/> Renewal <input type="radio"/> Change of premises	
APPLYING FOR <input type="checkbox"/> Foster care/adoption <input type="checkbox"/> International or Domestic Infant Adoption	
TYPE OF CHILD YOU ARE INTERESTED IN <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Either Age range _____ <input type="checkbox"/> Sibling group of up to _____ children <input type="checkbox"/> Specific child _____	FOR INTERNATIONAL ADOPTION ONLY INDICATE SPECIFIC COUNTRY OR AREA REQUESTED

Applicant 1

Share about yourself and where you live.

LAST NAME		FIRST NAME		MIDDLE NAME	FORMER NAMES
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single			
RACE <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White				ETHNICITY Hispanic <input type="radio"/> Yes <input type="radio"/> No	
CURRENT HOME (STREET) ADDRESS (P.O. BOX if required for mail delivery)					APT. NUMBER
CITY				STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS		
TRIBAL AFFILIATION	LANGUAGES SPOKEN	RELIGION	EDUCATION		
AREAS OF SPECIALIZED EDUCATION	OCCUPATION	NUMBER OF HOURS IN WORK WEEK	TYPICAL WORK SCHEDULE		

Have you lived at any other address in the past five years? No Yes If yes, complete below

Address 1
ADDRESS

CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Is there a second applicant in the home? No Yes If yes, complete the information below

Applicant 2

LAST NAME		FIRST NAME		MIDDLE NAME	FORMER NAMES
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Single			
RACE <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White				ETHNICITY Hispanic <input type="radio"/> Yes <input type="radio"/> No	
CURRENT HOME (STREET) ADDRESS (P.O. BOX if required for mail delivery)					APT. NUMBER
CITY				STATE	ZIP CODE
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS		
TRIBAL AFFILIATION	LANGUAGES SPOKEN	RELIGION	EDUCATION		
AREAS OF SPECIALIZED EDUCATION	OCCUPATION	NUMBER OF HOURS IN A WORK WEEK	TYPICAL WORK SCHEDULE		

Has this applicant lived at any other address in the past five years? No Yes If yes, complete below

Address 1			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

Address 2			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS
Address 3			
ADDRESS			
CITY	STATE	ZIP CODE	DATE MOVED TO THIS ADDRESS

If you have additional addresses to report, please attach an additional sheet of paper.

Emergency evacuation plan

Emergency contact person: Name a person who does not live in your household and would know how to contact you in case of emergency and/or evacuation.

NAME	PHONE
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If an emergency evacuation of a home is necessary due to disaster, indicate the specific location where foster children would go (e.g. name of local hotel, address of emergency contact person or foster child's relative):

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Do you have additional household members living in the home? No Yes

If yes, list all adults and children (not including foster children) living in the home below.

Household member 1				
LAST NAME		FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD		
Household member 2				
LAST NAME		FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD		
Household member 3				
LAST NAME		FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD		

Household member 4				
LAST NAME		FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD		
Household member 5				
LAST NAME		FIRST NAME		MIDDLE NAME
RELATIONSHIP TO APPLICANT(S)	DATE OF BIRTH	EXPECTED ROLE WITH FOSTER AND/OR ADOPTED CHILD		

If you have more household members to report, please attach an additional piece of paper.

Home (Description of home as it pertains to foster care of children)

SCHOOL DISTRICT IN WHICH HOME IS LOCATED			
Children placed in the home would attend the following schools			
ELEMENTARY		MIDDLE/JUNIOR HIGH	
HIGH SCHOOL		SCHOOL TRANSPORTATION <input type="checkbox"/> Bus <input type="checkbox"/> Other _____	
DOES APPLICANT HOME SCHOOL? <input type="radio"/> No <input type="radio"/> Yes – has applicant's home school plan been approved by the public school district? <input type="radio"/> Yes <input type="radio"/> No			
Does anyone smoke in the home? <input type="radio"/> No <input type="radio"/> Yes – fill in below			
WHO SMOKES IN THE HOME?			
WHAT IS YOUR PLAN TO PROVIDE A SMOKE-FREE ENVIRONMENT IN YOUR HOME, GARAGE, SURROUNDING AREA, AND CAR?			
Are there pets in the home? <input type="radio"/> No <input type="radio"/> Yes - fill in below			
WHAT TYPE(S) OF PETS?			
DO ANY PETS IN THE HOME POSE SAFETY CONCERNS? <input type="radio"/> Yes <input type="radio"/> No		DO PETS HAVE CURRENT VACCINATIONS? <input type="radio"/> Yes <input type="radio"/> No	
Dwelling information (check all that apply)			
<input type="checkbox"/> Own <input type="checkbox"/> Rent	<input type="checkbox"/> Mobile home <input type="checkbox"/> Basement	<input type="checkbox"/> Single family house <input type="checkbox"/> Multi-unit (apartment)	<input type="checkbox"/> Free standing solid fuel heating appliance
Sleeping arrangements (indicate where foster child will sleep)			
Bedroom floor/level	Occupants	Type of bed/s Crib, single, double, bunk (if bunk, indicate upper -U or lower -L)	Storage space for personal possessions
1.			
2.			
3.			

Bedroom floor/level	Occupants	Type of bed/s Crib, single, double, bunk (if bunk, indicate upper -U or lower -L)	Storage space for personal possessions
4.			
LIST AREAS AND/OR ITEMS IN YOUR HOME THAT ARE LOCKED AND/OR INACCESSIBLE TO FOSTER OR ADOPTED CHILD			

Experience with foster care and/or adoption, or any other licensing (including child care, adult foster care, etc.)

Have you ever applied, or worked with another foster care agency? No Yes – list all agencies (Minnesota and out-of-state)

Agency name	Address	Dates of involvement and outcomes

Are you currently or have you ever been licensed? No Yes – list all agencies (Minnesota and out-of-state)

TYPE OF LICENSE (check all that apply)		
<input type="checkbox"/> Family child care <input type="checkbox"/> Child foster care <input type="checkbox"/> Adult foster/community residential setting <input type="checkbox"/> Family adult day services <input type="checkbox"/> 245D-HCBS <input type="checkbox"/> Other		
LICENSE NUMBER (if known)	COUNTY/AGENCY/STATE	EFFECTIVE DATES OF LICENSE (if known)

Have you ever had a Minnesota Department of Human Services (department) license denied or revoked, or the subject of an unfavorable home study?

No Yes

EXPLAIN (include license type, denial or revocation, who completed the home study, etc.)
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Do you operate a business from your residence? No Yes

TYPE OF BUSINESS
DESCRIBE IMPACT HOME BUSINESS MAY HAVE ON YOUR FOSTER/ADOPTION PLAN

Substitute caregivers

Whom do you plan to use as a substitute caregiver for foster children or prospective adoptive children (e.g., personal care attendant, nurse, babysitter/respice care)?

NAME

AGE	PHONE AND/OR EMAIL ADDRESS			
STREET ADDRESS		CITY	STATE	ZIP CODE
RELATIONSHIP TO CHILD (if any)				

Transportation

Do you have a valid driver's license? No Yes

Do you own vehicles? No Yes

Are there age appropriate car seats? No Yes Will obtain Not applicable

Do you have adequate insurance for all vehicles? No Yes

Do you have access to public transportation? No Yes

DISTANCE TO NEAREST PICK-UP LOCATION

DESCRIBE ALTERNATIVE TRANSPORTATION PLAN IF FAMILY NOT HAVE AN OPERATING VEHICLE OR THE HOME IS NOT NEAR PUBLIC TRANSPORTATION
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Are you able to transport children to appointments or school when needed? Yes No

WHAT ALTERNATIVE TRANSPORTATION ARE YOU ABLE TO PROVIDE?
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References (required at initial application only)

Reference 1				
LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS			CITY	STATE ZIP CODE
EMAIL ADDRESS				PHONE

Reference 2				
LAST NAME		FIRST NAME		MIDDLE NAME
ADDRESS			CITY	STATE ZIP CODE
EMAIL ADDRESS				PHONE

Reference 3

LAST NAME		FIRST NAME		MIDDLE NAME	
ADDRESS			CITY	STATE	ZIP CODE
EMAIL ADDRESS					PHONE

Municipality (Required at initial licensure only)

Applicants for a non-relative residential program license issued by the Minnesota Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to inquire about local ordinance requirements. The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE

Child foster care applicants only

Applicant acknowledgment of public funding reimbursement for licensed services:

Department license holders who receive public funding reimbursement for services provided for care of children in a licensed program must acknowledge they will comply with funding requirements, that compliance with requirements may be monitored by the department's Licensing Division, and they know the consequences for not complying with requirements [Minnesota Statutes, section 245A.04, subd. 1 (h)].

As a foster care provider of a child, I acknowledge that I will receive public funding reimbursement for licensed services provided in my program and will comply with all requirements.

Notice about variances

All foster care licensing agencies are required to provide applicants with a summary of child foster care license requirements and standards. A variance to these requirements and standards may be requested in circumstances that do not jeopardize the health or safety of a child. County and child-placing agencies have authority to issue most variances. Only the department has authority to grant variances for dual licensure, child foster care maximum age requirements, chemical use problems, and variances regarding individuals disqualified for child foster care licensure based on background study information.

By signing below:

I acknowledge that I received the Applicant Privacy Notice: Child Foster Care and/or the Notice of Privacy Practices (DHS-3979). I also acknowledge that information I have provided on this application is complete and true. I agree that:

- I will comply with requirements in Minnesota Statutes, chapter 245A, and all applicable laws and rules, at all times during terms of the license.
- The department's commissioner representative has the right to request any documentation required by Minnesota rules or laws and to inspect my home and its grounds at any time. The documentation and inspection required by rules are necessary for the commissioner to determine whether I am complying with Minnesota rules and laws.
- Any documentation I provide or representations that I make to the commissioner's representative during the application process, during the time I am licensed, during an investigation or throughout the adoption process, will be complete and true. I understand that any misrepresentations or other violations of Minnesota rules and laws may result in immediate suspension, revocation or denial of a child foster care license, denial of an adoption home study, or termination of adoption services.

APPLICANT 1 SIGNATURE	DATE
APPLICANT 2 SIGNATURE	DATE

Authorized agent information (Required only for new applicants)

If more than one applicant, you must designate one applicant to act as the authorized agent authorized to accept service on behalf of all individual license holders of the program. Service on the authorized agent is on all license holders of the program. It is the responsibility of authorized agent to distribute mail received from the department within the facility as needed, and a response provided within stated timelines, when required.

Who is the authorized agent for your child foster care program?

NAME	EMAIL ADDRESS
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Applicant Privacy Notice: Child foster care

To apply for a license, you must provide identifying information, some of which is public, unless an identified reason for information to be not public. You must allow your program to be inspected by licensing agency staff.

What information is public?

- The applicant/license holder name, address and phone number
- License number, license status, services provided under the license, and any limitations on the license
- Licensing actions taken regarding application or license.

How license information is made available

Access information about a license by using the online Licensing Information Lookup search tool on the department's website. See [Licensing Information Lookup](#) or <http://mn.gov/dhs/general-public/licensing/>.

What if I do not want my identifying information made public?

There are circumstances when public identifying information can be limited to ensure the safety of children in foster care. If you believe this applies to you, talk with your licensing worker about limiting public information.

Will licensing information be shared with anyone?

Department staff may give information about you and your program to others authorized under state or federal law. Information is only shared on an as-needed basis to conduct investigations, or provide needed assistance to you or your program.

What if I refuse or withhold information?

Knowingly withholding relevant information, or giving false or misleading information for your license application, may result in denial of your application, or suspension or revocation of a license already issued.

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
1-800-657-3704 (toll free)
711 or 1-800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director, U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW, Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019 (voice)
1-800-537-7697 (TDD)
Complaint Portal:
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>