Commonwealth of Virginia
Department of Social Services
APPLICATION FOR DEPARTMENT APPROVED PROVIDER

Return to:	
Local Department Name	
Address	
Worker Name	Telephone

Check the type of care you wish to provide. Then fill in the sections appropriate for the type of care and sign the application. Please print legibly.

☐ Dual Approval (Foster, Adoptive or Resource Provider) ☐ Respite Only

I. IDENTIFYING INFORMATION FOR ALL ADULTS APPLYING TO BE A RESOURCE OR RESPITE PROVIDER.

Applicant A.

NAME OF APPLICANT (First, Middle or Maiden, Last)	MARITAL STATUS	RACE	BIRTHDATE	SOCIAL SECURITY NO.

STREET ADDRESS	TELEPHONE NUMBER (Include Area Code)

CITY, STATE, ZIP

DIRECTIONS TO YOUR HOME:

Applicant B.

NAME OF SPOUSE (First, Middle or Maiden, Last)	E-MAIL ADDRESS
STREET ADDRESS	TELEPHONE NUMBER (Include Area Code)

CITY, STATE, ZIP

DIRECTIONS TO YOUR HOME:

II. OTHER HOUSEHOLD MEMBERS (*Children and Adults*)

Full Name	Birth Date	Relationship	Part-time or Full-time Residence

III. CRIMINAL RECORD INFORMATION

Have you or your spouse ever been convicted of a felony or misdemeanor?

If yes, please explain:

Has any adult living in your home been convicted of a felony or misdemeanor?

If yes, identify who and explain:

I understand that the local department of social services will investigate my suitability as a provider of care to children by securing references and other information in accordance with approval standards.

I understand that I , my family and any adults living in my household must be willing to consent to a criminal record search if required by the local department of social services. Background checks will consist of a national fingerprint criminal record check, a Child Protective Services (CPS) child abuse and neglect central registry search, and a search of the Sex Offender Registry.

I understand that a DMV check will be conducted for all adults in the home who will be transporting the child.

I understand that I and other household members must submit to a tuberculosis screening/test and must also submit the results of a physical examination administered within the 12-month period prior to approval, from a licensed health care professional.

IV. ADDITIONAL INFORMATION/COMMENTS

Are there any physical or emotional limitations that might prevent you or should be considered in determining your capacity to care for children?

What are your reasons for wanting to become a foster, adoptive, resource or respite provider?

Have you ever applied to or worked with this or any other agency as a foster, adoptive, resource or respite provider?

Yes ☐ No ☐

If yes, I consent to sign a request to release information from the other agency in order to obtain information about previous applications and performance, and the local department of social services shall use that information in considering approval of this application.

REFERENCES

1. _____
2. _____
3. _____

V. SIGNATURES

I certify that the above information is accurate and true to the best of my knowledge. I understand that a false statement may disqualify my application from further consideration.

Applicant Signature _____Date _____

Signature of Spouse _____Date_____