Tennessee Department of Children's Services

Kinship 16.20 Packet

Complete the information below so that the information populates to all the other forms in the packet. (The information in the forms will not be visible until you print initially or look at print preview after all subsequent changes.)

Child's Name:	Type Here	Foster Parent Name:	Type Here
Child Date of Birth:	Type Here	Foster Parent SSN:	Type Here
Child SSN:	Type Here	Foster Parent Phone:	Type Here
Child Race:	Type Here	Foster Co-Parent Name:	Type Here
Child Sex:	Type Here	Foster Co-Parent SSN:	Type Here
Child Placement:	Type Here	Foster Co-Parent Phone:	Type Here
Child ID #:	Type Here	Foster Home:	Type Here

For CS-0660

Child # 1 Name:	Type Here	Child # 3 Name:	Type Here
Child # 1 DOB:	Type Here	Child # 3 DOB:	Type Here
Child # 2 Name:	Type Here	Child # 4 Name:	Type Here
Child # 2 DOB:	Type Here	Child # 4 DOB:	Type Here

Tennessee Department of Children's Services

Daily Rate Child Placement Contract

This contract is entered into between the Department of Children's Services and approved foster parents:

PAYEE Foster Parent Name		Social Security Number (last 4 digits)		Home Telephone	
Type Here		Type Here		Type Here	
Foster Co-Parent Name		Social Security Number (last 4 digits)		Alt. Telephone	
Type Here		Type Here		( ) -	
Street Address		City		State	Zip

For the care of:

Social Security Number (last 4 digits)	Child's Full Legal Name	
Type Here	Type Here	
Child ID #	Child's Birth Date	Placement Date
Type Here	Type Here	

RESPONSIBILITIES OF THE DEPARTMENT

The Department of Children's Services, through its undersigned representative, agrees:

1. To be responsible for the payment rate for the child based on the service type the foster parent is providing as described in the Payment Rate section of this contract. This payment represents the standard daily amount reimbursable to you as foster parents, including payment for room, board, clothing, transportation, and services to a child with special needs, when applicable. Payment will be made on or about the 1st and the 15th of each month for the corresponding two-week service period.

2. To be responsible for providing and assisting in completion the mandatory training and all requirements of DCS Policy 16.4, Foster Home Approval.

3. To encourage all eligible kinship/relative families to apply for Family First grants through the Department of Human Services and/or requesting flex funding when services are needed.

4. To provide casework services and applicable visitation services in accordance with DCS Policy.

5. To obtain the child's clothing and all personal items from the child's parent(s) when possible, and to provide an initial purchase of clothing for the child at the time of placement, when necessary. The FSW will advise foster parents when this purchase is allowable as well as the standard amount to be paid.

6. To reimburse fully approved foster parents for extraordinary transportation provided for the child in accordance with DCS policies.

7. To request payment from the Department of Children's Services, Fiscal Services Division for necessary medical and dental care for the child when not available through TennCare.

8. To provide any available information to the foster parents about the child's background, necessary to their care of the child, and to consult with them regularly regarding the child's care, health, education, development, and plan for permanency.

9. To provide binders and other materials to foster parents for use in preparing the child's Life Story Book.

10. To plan for visits and other contacts between the child and his/her birth family.

11. To advise the foster parents of the child's legal status and of pending court reviews, foster care review boards, or hearings, which may affect his/her legal status. Notice will be given a minimum of 5 days in advance whenever possible.

12. To assist and support the foster parents in accessing respite care, including supplemental respite when approved. When parents are in need of respite care for the children in their home but cannot secure it, the Foster Parent Support worker will assist in identifying safe, appropriate families to provide care.

13. To advise the foster parents of plans for removal of the child in accordance with Department of Children's Services' policy and rules governing such removals; to advise the foster parents when such removal may be appealed and the procedure for filing an appeal.

14. To prevent unnecessary moves for the child when possible by providing consultation with the foster parents regarding problems; to give prompt attention to the foster parent's request for removal of the child by immediately scheduling a Child and Family Team Meeting (CFTM).

15. To participate, when applicable, in a specialized casework plan relative to the needs of a particular child, e.g., adolescent, behaviorally disturbed, medically fragile, or other unique circumstance.

16. To provide foster parents with copies of the child's Permanency Plan and visitation agreements.

17. To include foster parents in all Child and Family Team Meetings for children in their care.

18. To assist the foster parent in providing transition support to all children moved from their home.

19. To support the foster parents in all appropriate ways including responding to all inquiries within 24-48 hours.

20. To uphold the Foster Parent Bill of Rights.

RESPONSIBILITIES OF FOSTER PARENTS

We, as foster parents, understand and agree:

1. To complete pre-service training and additional in-service training and requirements outlined in policy.

2. We will provide a nurturing, caring family life for children placed in our home and will consider the child as a member of the family. This would include providing transportation for the foster child to routine medical, psychological and educational appointments, visits to birth parents and/or siblings, recreational activities and trips to purchase clothing and supplies to meet the child's needs.

3. We are responsible to the Tennessee Department of Children's Services for the child's care, health, and education (if the child is of school age) during the period the child remains in our home. We agree to discuss all matters pertaining to the child's welfare with the assigned FSW and to participate in all Child and Family Team Meetings.

4. We will prepare a record of the child's stay in our home and maintain that record as a part of the child's Life Story Book. This may include pictures, mementos, and written records prepared on a regular basis, all of which shall accompany the child upon his or her departure from our home.

5. That under no circumstances will we allow anyone other than an authorized representative of the Department to remove, either temporarily, or permanently, the child from the foster home.

6. In case of serious illness or accident requiring the care of a physician, to notify the local DCS office immediately. We understand, however, that we are expected to use our own judgment in calling a doctor first in case of an emergency. In case of serious illness of any member of our family, we agree to notify the local DCS office.

7. We will not permit the child to leave our home for visits or to take the child outside the State without prior approval of the Department. We agree to discuss with the FSW in advance any plans regarding a change in our place of residence.

8. We will not accept any other adults or children as continuing members of our household while the Department has a child placed in our care without first consulting with the local DCS office and receiving approval.

9. We will notify the Department, in advance, when there is a need for respite services/care of children placed in our home, including when we are able to secure respite care ourselves. We will provide the child/youths daily rate to the respite foster parent up to two days per month. When in need of supplemental respite assistance, we will contact the Foster Parent Support Worker at least seven days in advance of the respite when able.

10. We will not attempt to adopt, file a petition to adopt, or take any steps whatsoever to adopt this child unless, after consultation with Department staff, the decision is made that adoption by us is in the child's best interest. It is our understanding, however, that if the child has been in our home for one year and we meet the qualifications required of other adoptive parents, that we will be given first preference for adoption of this child. We understand that until the termination or surrender of parental rights by both birth or adoptive parents is signed by the courts, no child is eligible for adoption.

11. The Department has the right to remove this child from our home at any time in accordance with rules governing such removals. In non-emergency situations such a removal will be preceded by a CFTM. We also agree to notify the local DCS office when removal of the child is at our request, giving the local office sufficient time to convene a CFTM should we find that for any reason we couldn't keep the child or properly care for the child.

12. We will not incur any expenses on behalf of the children, for which the Department could be held responsible without prior approval of the Department. This may exclude emergency medical services.

13. We will provide a monetary allowance to the child in our home.

14. We will immediately reimburse the Department any overpayment received for the care of the child.

15. We can request a mentor through the third-party contractor or through the local regional office to assist with normal foster parenting questions.

16. As per ***Policy 16.8, Responsibilities of Approved Foster Homes***: The Foster Parent Support (FPS)/Contract Agency staff are notified within one (1) working day, of any significant changes in the home (i.e. new address, additional persons living in the household, health, income (including Social Security benefits for the child, etc.). Failure to report any significant changes could affect the status of the foster home and may result in termination of foster care board payments and possibly an overpayment assessment.

RESPONSIBILITIES OF BOTH PARTIES

1. The Department of Children's Services and foster parents(s) will maintain the confidentiality of all information we receive about the child and his/her family. Strict standards of confidentiality of records and information shall be maintained in accordance with applicable state and federal law. All material and information, regardless of form, medium, or method of communication, provided to the foster parent(s) by the State or acquired by the parent on behalf of the State shall be regarded as confidential information in accordance with the provisions of applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. Such confidential information shall not be disclosed, and all necessary steps shall be taken by the foster parent(s) to safeguard the confidentiality of such material or information in conformance with applicable state and federal law, state and federal rules and regulations, departmental policy, and ethical standards. The foster parent(s) obligations under this section do not apply to information in the public domain: entering the public domain but not from a breach by the foster parent(s) of this Contract: previously possessed by the foster parent(s) without written obligations to the State to protect it: acquired by the foster parent(s) without written restrictions against disclosure from a third party which, to the foster parent's knowledge, is free to disclose the information: independently developed by the foster parent(s) without the use of the State's information: or disclosed by the State to others without restrictions against disclosure. Nothing in this paragraph shall permit foster parent(s) to disclose any information that is confidential under federal or state law or regulations, regardless of whether it has been disclosed or made available to the foster parent(s) due to intentional or negligent actions or inactions of agents of the State or third parties. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

2. Foster parent(s) and the State warrant they are familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations and will comply with all applicable HIPAA requirements in the course of this contract. Foster parent(s) and the State warrant they will cooperate in the course of performance of the contract so that both parties will be in compliance with HIPAA, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations. Foster parent(s) and the State will sign any documents that are reasonably necessary to keep both parties in compliance with HIPAA, including but not limited to business associate agreements.

RESPONSIBILITIES FOR SPECIAL/EXTRAORDINARY RATE

1. The Department shall be responsible for reviewing a special or extraordinary board rate in accordance with ***Policy 16.29 Foster Home Board Rates***.
2. The foster parents shall make any requested documentation available to the Department.

3. Both parties understand that the special or extraordinary rate expires twelve (12) months from the special/extraordinary rate effective date indicated at the top of this contract. To prevent termination, a re-evaluation shall be done in accordance with Departmental ***Policy 16.29 Foster Home Board Rates*** prior to the end of the twelve (12) month period. If a re-evaluation is not completed prior to the end of the twelve (12) month period, the daily rate for the above-mentioned child shall revert to a regular daily rate until a re-evaluation is completed which indicates the child qualifies for a different rate.
4. Foster parents shall be responsible for reimbursing the Department for any overpayments that may occur.
5. If any terms in this section conflict with terms in Department or foster parent responsibilities, the terms in the Responsibilities for Special/Extraordinary Rate shall control.

Payment Rate

Payment rates shall be made to the foster parent as follows:

Service Type	Payment per day
Emergency Resource Home Placement (72 HRS) (0-18)	$50.00
Expedited Foster Care Placement-Paid (0-18)	$14.12
Extraordinary Rate Extension of Foster Care (18-20)	$ 40.00
Extraordinary Rate, 40 (0-18)	$ 40.00
Extraordinary Rate, 50 (0-18)	$ 50.00
Extraordinary Rate, 60 (0-18)	$ 60.00
Regular Board Rate (0-11)	$ 27.53
Regular Board Rate (12-18)	$ 31.56
Regular Board Rate Extension of Foster Care (18-20)	$ 30.06
Regular Board Rate w/Daycare age 0-2 (0-2) (out of state only)	$ 47.59
Regular Board Rate w/Full-Time Daycare age 3 and up (3-12) (out of state only)	$ 44.03
Regular Board Rate w/Part-Time Daycare age 3 and up (3-12) (out of state only)	$ 39.10
Special Circumstance Rate (0-11)	$ 30.28
Special Circumstance Rate (12-18)	$ 34.71
Special Circumstance Rate Extension of Foster Care (18-20)	$ 33.06
Special Circumstance Rate w/Daycare age 0-2 (0-2) (out of state only)	$ 50.21
Special Circumstance Rate w/Full-Time Daycare age 3 and up (3-12) (out of state only)	$ 46.65
Special Circumstance Rate w/Part-Time Daycare age 3 and up (3-12) (out of state only)	$ 41.72

Payment rates shall be adjusted by the Department as necessary, without generating a new contract, to ensure that the foster parent is paid for the service type the foster parent is currently providing. For example, when an expedited foster home becomes fully approved, the Department shall adjust the payment rate from the Expedited Foster Care rate to the corresponding Regular Board rate.

TERMINATION

This contract shall terminate on the earliest date of:

1. The removal of the child by an authorized representative of the Department of Children's Services;
2. Violation of the terms of this contract by the foster parents;

3. The end of the period allowed for the contract service type.

For kinship families:

This contract is valid 120 days after placement of the child. This contract may be extended to allow for completion of home approval. Authorization by the Regional Administrator is required to extend this contract or to modify any of its terms. This contract will terminate upon removal of the child by an authorized representative of the Department of Children's Services or upon the violation of this contract by the kinship care parents.

I ☐ agree or ☐ disagree to receive the following payments for _____ :

☐ Regular Daily Board Payment
☐ Kinship/Expedited Board Payment
☐ Emergency Placement

SIGNATURES

By affixing our signatures hereto, both parties affirm the terms of the contract and confidence in each other to fulfill the responsibilities thereof.

Entered into this the _____ Day of _____, _____.

PAYEE Foster Parent Signature	Work Telephone Number
	( ) -
	Home Telephone Number
	Type Here
Foster Co-Parent Signature	Work Telephone Number
	( ) -
	Home Telephone Number
	Type Here
Family Service Worker/Foster Parent Support Worker Signature	Work Telephone Number
	( ) -
	After Hours Telephone Number
	( ) -

Office Street Address			
City		State	Zip Code
			-
County		Region	

CONTRACT TERMINATED			
	Month	*Date*	*Year*

_____ _____

DCS Staff *Date*

Always check the "Forms" Website for most current version. This form may not be altered.
Distribution: Regional Administrator, Designee, Interdependent Living Office, Foster Home Case Record, Child's Case Record

RDA 2877

Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information TO the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**			

Name of Provider/School/Entity Releasing Information TO DCS: _____

Type of Information Requested (check ONLY one) ***You must hand write/type in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:
2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:
4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:
5. ☐ **Employment Records**
   Specific Information Requested:
6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:
7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

kidcentral tn
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RDA 11016

A. AUTHORIZATION FOR RELEASE TO DCS

☐ **I, _____ hereby authorize release of the information specified on page 1A, to any representative of the Tennessee Department of Children's Services bearing this release or a copy of this release, including any information deemed to be confidential. I hereby direct you as an individual or agency to release this information upon request of said representative. This release is executed with the full knowledge and understanding that the information released is for the official use of the Department of Children's Services. Failure to grant access to the requested information may result in a court order for the information.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 1A of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ OR This section was read to me. _____

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

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Tennessee Department of Children's Services

Authorization for Release of Information and HIPAA Protected Health Information FROM the Department of Children's Services and Notification of Release

This information refers the in the individual whose information is being released.

Name: Last		**First**		**Middle**	
Other Legal Names:					
Address					
City		**State**		**Zip Code**	
SSN	- -	**DOB**		☐ **Male** ☐ **Female**	
Telephone Numbers: Cell	( ) -	**Home**			

Name of Provider/School/Entity Receiving Information FROM DCS::

_____

Type of Information Requested (check ONLY one) ***You must hand write in specific information being requested*****:**

1. ☐ **Education records, including transcripts, GED, TCAP, Special Education**
   Specific Information Requested:

2. ☐ **Psychological/Psychiatric/Mental Health Treatment Records, alcohol/drug/substance abuse treatment records, and any associated test results. *Does not apply to employees or volunteers*.**
   Specific Information Requested:

3. ☐ **Medical records, including examinations, laboratory tests, and prescribed treatments. *Does not apply to employees or volunteers*.**
   Specific Information Requested:

4. ☐ **Background/Criminal History Checks, including Polygraph, and Fingerprint Results**
   Specific Information Requested:

5. ☐ **Employment Records**
   Specific Information Requested:

6. ☐ **Personal Finance/Credit History/Insurance Records (as applicable)**
   Specific Information Requested:

7. ☐ **Other**
   Specific Information Requested:

Purpose of the Requested Release/Disclosure:
Check all that apply: ☐ **Arrange/Access Services** ☐ **CPS Investigation** ☐ **Juvenile Court Case**
☐ **Other:** _____

Signature:_____ **Date:**_____

OR

Signature of Authorized Representative*:_____ **Date:**_____

*Authorized Representative means you have legal proof you can act for this person.

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

B AUTHORIZATION FOR DCS FROM RELEASE

☐ **I, _____ hereby authorize the Tennessee Department of Children's Services to release the information specified on page 1, to the person/entity specified on page 1B.**

I understand that there are laws and regulations protecting the confidentiality of certain written and oral information such as: Title 33 of the Tenn. Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. My signature indicates I have received a copy of this authorization. I hereby request and authorize the release of records or information as specified on page 1B of this release. I understand I may revoke this authorization in writing at any time, but it will not affect disclosures already made in reliance on this authorization. This release takes effect on the date I signed it.

HIPAA Authorization for Release of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand the following: (1) This authorization is voluntary. (2) If the person or organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. (3) My ability to receive health care, eligibility for health care, or the payment for my health care will not be affected if I do not sign this form. (4) I may see and copy the information described on this form if I ask for it, and I get a copy of this form after I sign it. (5) I may revoke this authorization at any time by notifying the person/organization(s) in writing, but if I do it won't have any effect on actions taken before the revocation was received. (6) Any release made in reliance on this authorization prior to receiving revocation of the release shall not constitute a violation of HIPAA or my confidentiality rights.

I have read this section._____ **OR** **This section was read to me. _____**

Initial *Initial*

If the individual who is the subject of the information requested is a Child Under the Age of 18, the Child's Parent(s) or Legal Guardian Must Sign This Release. EXCEPTION: Release of records under category number 2 for a minor age 16 or older, requires the signature of that minor. Release of records under categories 2 and 3 should be signed by the youth, regardless of age, if the youth consented to the health care instead of the parent, guardian, or custodian consenting.

One signature required:

Print Name	*Signature*	*Date*

OR

Name of Authorized Representative (Print)	*Signature of Authorized Representative*	*Date*

Signer's Relationship to client and authority to release confidential information	☐ Self ☐ Parent ☐ Legal Guardian* ☐ Legal Custodian*	
☐ **Conservator***	☐ **Personal Representative for HIPAA***	☐ **Other*, specify:**

Proof of authority to release information, such as a court order or Power of Attorney document, must be provided.

Name of Witness (Print)	*Signature of Witness*	*Date*

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Distribution: Original Child's case File

Tennessee Department of Children's Services

Background Check History and IV-E Eligibility Checklist

Date background check started:				
Requester's Name:		Organization:		
Agency/Group Home/YDC:		Date of Hire:		
Applicant's Full Name:		Other Legal Names:		
Social Security Number:		Date of Birth:		
Email:		Telephone:		
Addresses Last Six Months:				
States Resided in Last Five Years:				
Reason for Background Check:	☐ LEA Employee	☐ DCS Employee	☐ DCS Volunteer	☐ Contract Provider Employee
☐ Other Child Care Related	☐ Foster Parenting	☐ ICPC/ICJ Request	☐ Other (Specify):	

Copies of all results received must be attached with this form. See form instructions, page 2, for Background Checks schedule.

Type of Background Check	Employee	Foster Parent/Household Member	Central Office Use Only
Local Law Enforcement Check			
National Sex Offender Registry			
Vulnerable Persons Abuse Registry			
TN Felony Database Clearance			
Drug Offender Registry			
CS-0741 DCS Database Search			
Out-of-State Child Abuse/Neglect Check			
Fingerprint Results (TBI/FBI)			
Purpose Code X III Name Check			
Driver's License			
Other (Specify):			

Comments:

Results Reviewed by:		**Date:**

Requester's Signature

Central Office Use Only

Date Reviewed	Date Response	Date Reviewed	Date Response

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Original (as applicable), Employee (Confidential Section of the Official Personnel File), Foster Parent File, Volunteer File

Tennessee Department of Children's Services

Discipline Policy

Discipline is a teaching process that is initiated by a trauma informed caregiver who is able to identify the underlying need of a foster child. It is through this process that a child develops the self-control, self-reliance, resiliency, and orderly conduct appropriate life skills necessary to assume responsibilities, make daily living decisions and live according to accepted levels of social behavior. The goals of discipline for foster children are:

- To problem-solve appropriate ways of getting needs met (i.e., needs for attention, ways to express feelings, etc.)
- To feel good about relationships with other adults and other children
- To have a positive self-concept
- To acquire appropriate regulation skills on their own to be able to relate and reason when their needs are not being met
- To have secure attachment and connection with other adults and children
- To be resilient in the face of adversity, causing them to have a foundation of true self-esteem

In order to accomplish these goals, the following guidelines should be followed:

- Encouragement and praise of good behavior is often more effective than punishment and is a must in disciplining a child. The child's acceptance of discipline and ability to profit by it depends largely upon feeling that he/she is liked, accepted and respected.
- Practice regulation methods that were taught in Pre-Service training to help reroute the child in times of dysregulation.
- Approach the child with words and actions that will form secure attachment and connection.
- Discipline must be determined on an individual basis and meet the child at the developmental and cognitive level of the child.
- All discipline shall be limited to the least restrictive appropriate method and administered in an appropriate manner.

The following forms of punishment must **not** be used:

1) Corporal Punishment such as slapping, spanking, or hitting with any object,
2) Excessive exercising (particularly of a military nature), running laps, repetitive sit-ups, etc.
3) Cruel and unusual punishment,
4) Assignment of excessive or inappropriate work,
5) Denial of meals and daily needs,
6) Verbal abuse, ridicule or humiliation,
7) Permitting a child to punish another child,
8) Chemical, physical, or mechanical restraints (ex; use of psychotropic medications as a restraint),
9) Denial of planned visits, telephone calls, or mail contact with birth family, attorney, siblings, Family Service Worker, pre-adoptive family, or attorney,
10) Seclusion as a punishment,
11) Threat of removal from the foster home, or
12) Any discipline that occurs more than 24 hours after the incident.

I have read this discipline policy of physical punishment and do comply with it.

Foster Parent Signature	Date
Foster Parent Signature	Date

Please disregard all previous versions prior to the date listed below. Always check "Forms" Website for most current version.

Tennessee Department of Children's Services

Fingerprint Card Information

All information is required for fingerprinting and must be complete and accurate.
(Please Print All Information)

OIR # **TN920190Z** **OCA #**

Fingerprint Date:	**Fingerprint Time:** ☐ **A.M.** ☐ **P.M.**	**Fingerprint Location:**	**Investigation ID#:**

Complete Legal Name	**Date of Birth**	**Related Case Name**	**Relative**	**Non-Relative**
	- -		☐	☐
Last Name First Name Middle Name	*Month Day Year*	*Name*		

Complete Street Address	**Phone Number**
Street City State Zip Code	*Phone #*

Driver's License Number	**Issuing State**	**Reason for Printing**		
		☐ (CD)	☐ (FC)	☐ (AD)
		DCS Employee/Volunteer/Intern	Foster Care	Adoption

Social Security Number (SSN)	**Place of Birth**
- -	
	City County State
Military ID Number if different from SSN	**Aliases Used**
	(*Such as Maiden Name, previous Married Names, or any other legal name)*

Height		**Weight**	**Gender/Sex**	**Citizenship**
			Male ☐ **Female** ☐	**USA** ☐ **Other** ☐
Feet	***Inches***	***Pounds***		

Hair Color		**Eye Color**		**Race**	
Brown	☐	**Blue**	☐	**American Indian or Alaska Native**	☐
Black	☐	**Brown**	☐	**Asian or Pacific Islander**	☐
Gray or partially gray	☐	**Gray**	☐	**Black or African American**	☐
Blonde or Strawberry	☐	**Green**	☐	**Hawaiian Native or Other Pacific Islander**	☐
Red or Auburn	☐	**Hazel**	☐	**Hispanic or Latino**	☐
Sandy	☐	**Multicolor**	☐	**White (non-Hispanic)**	☐
White	☐	**Other**		**Other**	
Unknown or Bald	☐	**Unknown**	☐	**Unknown**	☐

Results to**:**	Fax #: **( ) -**	Applicant Signature:

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

Tennessee Department of Children's Services

Relative/Kinship Home Study

Home Study Preparer's Name:		Date:		Region:	
CAREGIVER INFORMATION:					
Primary Caregiver:	Last Name:		First Name:	Middle Initial:	
Date of Birth:		SSN:		Email Address:	
Cell Phone No:		Emergency/Work Phone No:			
Marital Status:		Employer:		Monthly Income:	
Secondary Caregiver:	Last Name:		First Name:	Middle Initial:	
Date of Birth:		SSN:		Email Address:	
Relationship to Applicant:					
Cell Phone No:		Emergency/Work Phone No:			
Marital Status:		Employer:		Monthly Income:	
Household Address:					

KINSHIP CHILD PLACEMENT INFORMATION					
Last Name:		First Name:		Middle Initial:	
Date of Birth		Relationship to Caregiver(s):			
Last Name:		First Name:		Middle Initial:	
Date of Birth		Relationship to Caregiver(s):			
Last Name:		First Name:		Middle Initial:	
Date of Birth		Relationship to Caregiver(s):			

HOUSEHOLD MEMBER INFORMATION:					
A. Children – (Birth or Adopted):					
Last Name:		First Name:		Middle Initial:	
Date of Birth:	SSN:		Relationship to Applicant/Co-Applicant:		
Last Name:		First Name:		Middle Initial:	

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Distribution:

CS-4254, 3/24

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RDA 10016

Date of Birth:		**SSN:**		**Relationship to Applicant/Co-Applicant:**	
Last Name:		**First Name:**		**Middle Initial:**	
Date of Birth:		**SSN:**		**Relationship to Applicant/Co-Applicant:**	
B. Other Adults in the Home:					
Last Name:		**First Name:**		**Middle Initial:**	
Date of Birth:		**SSN:**		**Relationship to Applicant/Co-Applicant:**	
Last Name:		**First Name:**		**Middle Initial:**	
Date of Birth:		**SSN:**		**Relationship to Applicant/Co-Applicant:**	

ASSESSMENT: Provide a detailed response to each question avoiding one word or sentence responses. As an assessor, follow up questions should build upon responses ensuring a complete understanding of the caregiver and home environment.

A. Caregiver Assessment:

What is the caregiver's understanding of the current situation (why placement is needed)?

Describe the caregiver's relationship with the child and their family:

Does the caregiver have any concerns about meeting the child's needs/ keeping the child safe?

Are there ways DCS can help alleviate concerns or increase safety?

What is the plan for supervision or childcare?

Describe the caregiver's support system:

Describe the caregiver's plan for respite to maintain self-care:

Describe a contingency plan for emergency situations:

Has the proposed caretaker and other household members stated that they are in basic, good health and free of communicable diseases?

List all current prescription medications (medication, dose, frequency, any controlled substance) being taken by any members of the home:

Has anyone in the home (in the past or currently) received mental health services including counseling, hospitalization, and/or medication management noting date and length of services?

Are all household members willing to receive pertussis and an annual flu shot to care for children under 18 months old or have special health care needs?

Discuss the outcome of the criminal background checks documenting circumstances, actions, and lessons learned.

B. Home Safety Assessment: The answers provided should not be used to automatically disqualify, but rather provide an opportunity to partner with the caregiver to resolve safety issues that may be a barrier to placement.

Safety Measure	Yes	No	What is needed to support the family?
Water: Does the home have safe water for drinking and bathing?	☐	☐	
Heating/cooling: Does the home have heating and/or cooling that is appropriate for the geographic region?	☐	☐	
Electricity/lighting: Does the home have access to electricity and/or lighting, based on the children's needs?	☐	☐	
Insects and rodents: Is the home free of insect and rodent infestation? This topic intends to reference infestation that creates a safety or health issue.	☐	☐	
Pets: Are pets at the home safe to be around (that is, do not pose a health or safety threat)? Note: Pet vaccinations are required with proof provided within 30 days of approval.	☐	☐	
Outdoor areas: Is the outdoor space that children will have access to safe, based on their age and development? Consider potential hazards: swimming pools and hot tubs, bodies of water like lakes and rivers, street traffic, railroad tracks, farm animals and equipment, trampoline, and wells. **Completion of Water Hazard/Pool Safety Assessment Tool**	☐	☐	
Other hazards: Is the home free from any other safety hazards in the home or surrounding area that children have access to? This may include overflowing garbage, uncontained pet waste, mold, peeling lead paint, and excessive debris.	☐	☐	
Tools and hazardous materials: Are tools and hazardous materials stored out of reach of children? This may include power or yard tools, saws, axes, pesticides, gasoline cleaning supplies, knives, alcohol and tobacco.	☐	☐	
Medications: Are prescription and over-the-counter medications (including vitamins, herbal remedies, and pet medications) stored out of reach of children?	☐	☐	

Exceptions: A child who takes their own medication, or who has emergency medication, like an EpiPen or inhaler.			
Firearms and weapons: Are firearms, weapons, and ammunition stored locked, unloaded, and inaccessible to children? This includes firearms/weapons secured and ammunition stored separately.	☐	☐	
Phone: Does the family (including children) have access to a working phone or way to call for help in an emergency? Includes cell phones, landlines, Wi-Fi calling, and shortwave radios.	☐	☐	
Fire hazards: Is the home free from fire hazards such as: ● Exposed wires or electrical outlets ● Flammable materials within 3 feet of a fire source, like a space heater or wood stove ● Multiple extension cords connected together	☐	☐	
Smoke and carbon monoxide detectors: Does the home have a properly functioning: ● Smoke detector on each floor ● Carbon monoxide detector, if the home has a gas appliance (boiler, furnace, stove, dryer, water heater), propane space heater, fireplace, wood stove, or attached garage on each floor.	☐	☐	
Fire extinguisher: Does the home have at least one operating fire extinguisher that is easy to get to?	☐	☐	
Exits from children's sleeping spaces: Is there at least one exit (a door or window) from each child's sleeping space that is: ● Unblocked ● Large enough for each child to get through	☐	☐	
Sleeping space: Does the home have a safe sleeping space with bedding for each child? Typically, each child should have their own bed. **For children under 12 months:** Sleep space must be safe for infants, with appropriately sized bedding, and free of blankets and other items like pillows and stuffed animals. Bedding options are a bassinet, crib, pack and play, Native American baby board, or baby box. **For children over 12 months (based on age and development):** Options are a bed, bunk bed, sleeper sofa, or futon. An air mattress or couch may be used temporarily until children have a permanent bed. Toddlers may continue to sleep in a crib or pack and play. **Considerations:** ● **Child preferences:** Ask children (without caregiver present) what they're comfortable with for room and sleeping arrangements.	☐	☐	

Consider the needs of LGBTQIA+ children, especially if there are arrangements based on gender. ● **Bed sharing (over 1) or room sharing:** Consider flexibility for cultural or community standards, or to support healing from trauma. ● **Common space:** Consider flexibility for those who have limited living space. Rooms other than bedrooms can be sleeping spaces. If using a common space for sleep, ensure the child has space for privacy. ● **Past sexual trauma:** For a child with past sexual trauma or sexualized behaviors, it's especially important that they have their own sleeping space.			
Transportation: Does the caregiver have a way to transport the children to appointments and activities including car/booster seats, valid driver's license and car registration/proof of insurance? May include: Public transportation, access to someone else's car, or a plan for others to support.	☐	☐	

References:		
Name:	**Phone and address:**	**Relationship:**
Reference Comments:		
Name:	**Phone and address:**	**Relationship:**
Reference Comments:		

Additional Notes:

PLACEMENT RECOMMENDATION:

What is your placement recommendation for this caregiver?

☐Yes, recommend placement.
☐Can place once critical items are addressed.
☐Do not place.

Provide comments explaining the reason for the placement recommendation. If items need to be addressed, note below.

Agency Worker Signature:	**Date:**
Approve ☐ Deny ☐ Conditions for Placement to be made:	
Supervisor Signature:	**Date:**
Team Coordinator Signature:	**Date:**
Regional Director/Designee Signature:	**Date:**

Verifying Discussions

Discussed with caregiver:		**Primary Caregiver**	**Secondary Caregiver**
Medication Tracking	**Caregiver Initials:**	_____	_____
Foster Care Board Rate	**Caregiver Initials:**	_____	_____

Tennessee Code Annotated, Section 37-2-414(e)

It is an offense for a foster parent from a kinship placement to knowingly allow a child in the foster parent's care to visit with the child's parent if the foster parent had knowledge of a current court order prohibiting the parent from visiting with the child. (B) A first violation of subdivision (e)(2)(A) is a Class C misdemeanor punishable by a fine only. (C) A second or subsequent violation of subdivision (e)(2)(A) is a Class B misdemeanor.

	Primary Caregiver	**Secondary Caregiver**
Caregiver Initials:	_____	_____

Tennessee Department of Children's Services

FOSTER PARENT OATH TO ABIDE

Foster Home Name: Type Here

Foster Parent Initials	Co-Parent Initials	**Confidentiality**
		A great deal of sensitive and confidential information about children and families served by Department of Children's Services (DCS) will be shared with foster parents. DCS believes that protecting sensitive and confidential information is critical to building and maintaining positive relationships and requires that all persons affiliated with DCS adhere to a practice of protecting that kind of information. DCS requires all potential and active foster parents to sign an oath to refrain from sharing any information about children or families with individuals or agencies, including sharing on social media, not authorized by a child's Child and Family Team, to include birth parent, to share that information.
Foster Parent Initials	Co-Parent Initials	**Report Child Abuse and Neglect**
		I understand it is my duty to report suspected child abuse or neglect and to abide by child safety restraint laws. I do solemnly pledge to report any suspected child abuse or neglect to the proper authorities. I realize that failure to report is a violation of the law and is not in the best interest of children. I also pledge to adhere to child restraint laws while transporting children in my vehicle.
Foster Parent Initials	Co-Parent Initials	**Drug and Medication Expectations**
		I have read and understand the Protocol for Drug and Medication Expectations for Approved Foster Homes to ensure a drug-free environment. For Relative/Kinship Caregivers: If applicable, I have been instructed on how to complete the medication log.
Foster Parent Initials	Co-Parent Initials	**Proper Use of Car Seats**
		I pledge to adhere to child restraint laws while transporting children in my vehicle.
Foster Parent Initials	Co-Parent Initials	**Handgun Carry Permit**
		I have provided DCS with a copy of the permit when applicable. I understand that I am responsible for the safety of the children in my care and will always exercise extreme caution. (Attach copy of permit.) ☐ **N/A**
Foster Parent Initials	Co-Parent Initials	**Foster Parent Agreement with pool or other water hazards on their property**
		Compliant with ***Water Hazard/Pool Safety Assessment Tool*** and local ordinances. ☐ **N/A**
Foster Parent Initials	Co-Parent Initials	**Foster Parent Involved searches:**
		Policy 31.4 has been reviewed with me, my concerns discussed, and questions answered.

Foster Parent Initials	Co-Parent Initials	**Foster Home Disclosure Acknowledgement**
		I have received information and understand that serving as a foster parent is a privilege and that the approval and re-approval processes are intentionally rigorous to ensure the best able to care for children who are abused or neglected become or remain foster parents. I understand that information regarding my performance and quality of care as a foster parent will be shared between agencies if I choose to transfer or re-activate my services for an agency other than my initial assessment for the purpose of caring for children in state's custody. ☐ **N/A for Relative/Kinship Caregivers**

I confirm that the Oath to Abide has been reviewed with me and I understand my responsibilities as a foster parent:

_____ _____

Applicant's Signature *Co-Applicant's Signature*

_____ _____

Date *Date*

_____

Witness

_____

Date

Tennessee Department of Children's Services

Full Disclosure Statement: Permanency Options for Relative or Kin Caregivers

Child's Name:	Type Here	DOB:	Type Here	☐ Custodial	☐ Non-Custodial
Child's Name:	Type Here	DOB:	Type Here	☐ Custodial	☐ Non-Custodial
Child's Name:	Type Here	DOB:	Type Here	☐ Custodial	☐ Non-Custodial
Child's Name:	Type Here	DOB:	Type Here	☐ Custodial	☐ Non-Custodial
Child's Name:		DOB:		☐ Custodial	☐ Non-Custodial

My signature below indicates that

1. The DCS worker has informed me of the available options and services to me as a relative or kin caretaker;
2. I have had the opportunity to ask questions and have my questions answered;
3. I have been provided a copy of the **Guide to Full Disclosure of Permanency Options**;
4. I have viewed the video at the following link:
   Relative Caregiver (tn.gov)

Signature of Relative or Kin Caregiver _____ Date _____

Signature of Relative or Kin Caregiver _____ Date _____

My signature below indicates that I have viewed the provided video with the family, provided a copy of the Guide to Full Disclosure to Permanency Options to this relative or kin, and explained the contents of the guide to the relative or kin. If there are questions that I cannot answer, I will provide those answers as soon as possible. DCS will provide ongoing discussion regarding permanency options through Child and Family Team Meetings (CFTMs), home visits, court contacts, Foster Care Review Board meetings and family outings/visitations.

Signature of DCS Staff _____ Date _____

DCS Staff Telephone Number _____

DCS Staff Email Address _____

Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:	Type Here	Child DOB:	Type Here	Person ID:	Type Here

Initiated By: _____ Title: _____ Date: _____

Revised By: _____ Title: _____ Date: _____

Person Providing Information to DCS: _____ Relationship to Child/Youth: _____

Current insurance coverage ☐ Yes ☐ No ☐ Unknown **If yes, provide details:** _____

Child/Youth Information

Name of Child/Youth:	Type Here	E-mail Address:		SSN:	Type Here

DOB:	Type Here	Sex:	Type Here	Race:	Type Here	Hispanic:	☐ Yes ☐ No	U.S. Citizen:	☐ Yes ☐ No Provide Birth Certificate Verification

Is Child/Youth of Native American Descent?	☐ Yes ☐ No ☐ Unable to Determine	If "Yes" Tribal Affiliation	

Child/Youth's Marital Status *(check one)*	☐ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Has Youth been placed in out of home care prior to this custody episode? If yes, please list dates and placements:	☐ Yes ☐ No

Current Description of the Child/Youth

Physical Description Date		Primary Language Spoken	

Height		Weight		Hair Color		Eye Color	

Religion:		Identifying Marks or Tattoos:	

Special Needs/Disabilities:	
Special Medical Equipment:	
Scheduled Appointments: (*date, provider, location, type of appt*)	

Allergies/Adverse Reactions:	☐ Yes ☐ No		
Medication:		Describe reaction:	
Food:		Describe reaction:	
Insect Sting:		Describe reaction:	
Other:		Describe reaction:	

Medical modified/Religious diet?	☐ Yes ☐ No	If yes, describe	

Medications: Prescribed and Over the Counter

Current medications (*name, route, frequency, dosage & days of meds left)*	

Child Name:	Type Here Error! Reference source not found.	**Child DOB:**	Type Here Error! Reference source not found.	**Person ID:**	Type Here

Are meds given in school?	☐ Yes ☐ No	**Which meds?**	
Consent signed for psychotropic meds:	☐ Yes ☐ No ☐ N/A	**Next med appointment:**	
Has Foster Parent received medication:	☐ Yes ☐ No	**Explain:**	

Health History of Child Explain any items checked Now/Past in "COMMENTS" section

No	Now	Past		No	Now	Past	
☐	☐	☐	Birth defects	☐	☐	☐	Gastrointestinal problems
☐	☐	☐	Vision problems	☐	☐	☐	Kidney/urinary problems
☐	☐	☐	Hearing problems	☐	☐	☐	Hepatitis/liver problems
☐	☐	☐	Skin problems	☐	☐	☐	Cancer
☐	☐	☐	Head injuries	☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Headaches	☐	☐	☐	Autism/Asperger's (circle one)
☐	☐	☐	Sickle cell disease	☐	☐	☐	Developmental delays
☐	☐	☐	Anemia/blood disorder	☐	☐	☐	Learning disability
☐	☐	☐	Epilepsy/seizures	☐	☐	☐	Sleep problems
☐	☐	☐	Bedwetting	☐	☐	☐	Incontinence: ☐ Urine ☐ Stool
☐	☐	☐	Diabetes	☐	☐	☐	Other medical *(describe below)*
☐	☐	☐	Asthma/Respiratory Disease	☐	☐	☐	Accidents *(describe below)*
☐	☐	☐	Heart murmur	☐	☐	☐	Hospitalizations *(describe below)*
☐	☐	☐	Heart problems	☐	☐	☐	Surgeries *(describe below)*
☐	☐	☐	High blood pressure	☐	☐	☐	Problems with anesthesia
☐	☐	☐	Physical disabilities	☐	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☐ No	**If yes, where and why:**	

Comments/Additional health information/ongoing health related services:	

Childhood Illnesses

No	Yes	Approx. date		No	Yes	Approx. date	
☐	☐		Measles	☐	☐		Chicken pox
☐	☐		German measles	☐	☐		Scarlet fever
☐	☐		Mumps	☐	☐		Rheumatic fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "COMMENTS" section

No	Yes		No	Yes	
☐	☐	Neglect	☐	☐	Domestic violence
☐	☐	Physical assault/abuse	☐	☐	School violence
☐	☐	Sexual assault/abuse	☐	☐	Community violence
☐	☐	Emotional abuse	☐	☐	Extreme interpersonal violence
☐	☐	Traumatic loss/separation	☐	☐	Natural disaster
☐	☐	Extended illness/medical trauma	☐	☐	Impaired caregiver (substance abuse/mental illness)

☐	☐	Serious injury	☐	☐	Other trauma, describe:

Child Name:	Type Here	**Child DOB:**	Type Here Error! Reference source not found.	**Person ID:**	Type Here

Has abuse been reported? ☐ Yes ☐ No ***If no, call CPS 877-237-0026***

Child Strengths

Comments/Additional health information:	

Behavioral/Mental Health History

No	Now	Past	
☐	☐	☐	Intense anger, if yes, describe
☐	☐	☐	Oppositional, if yes, describe
☐	☐	☐	Negative Peer Association, if yes, describe
☐	☐	☐	Extreme Attention Seeking, if yes, describe
☐	☐	☐	Makes False Statements, if yes, describe
☐	☐	☐	School Difficulties, if yes, describe
☐	☐	☐	Damage of Property, if yes, describe
☐	☐	☐	Habitual Lying, if yes, describe
☐	☐	☐	Stool Smearing, if yes, describe
☐	☐	☐	Stealing, if yes, describe
☐	☐	☐	Runaway, if yes, describe
☐	☐	☐	Hoarding, if yes, describe
☐	☐	☐	Problems with concentration and attention, if yes, describe
☐	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☐	☐	☐	Requires Constant Supervision, if yes describe
☐	☐	☐	Anxiety, if yes, describe
☐	☐	☐	Depression, if yes, describe
☐	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☐	☐	☐	Fire-setting, if yes, describe
☐	☐	☐	Animal cruelty, if yes, describe
☐	☐	☐	Animal fear, if yes, describe
☐	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☐	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☐	☐	☐	Sexual aggression, if yes, describe
☐	☐	☐	Had homicidal thoughts, if yes, describe
☐	☐	☐	Had suicidal thoughts, if yes, describe
☐	☐	☐	Attempted suicide If yes, describe
☐	☐	☐	Had other mental health or behavioral problems, if yes, describe
☐	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☐ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☐ No
If yes, diagnosis, when, where?	
Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☐ No
If yes, diagnosis, when, where?	
Has the Child/Youth/Family received in-home services?	☐ Yes ☐ No
If yes, when, where?	
Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☐ No

Child Name:	Type Here	**Child DOB:**	Type Here	**Person ID:**	Type Here

If yes, when, where?

Alcohol/Drug Abuse History

No	Now	Past	Frequency	(Xs per day/week/month)
☐	☐	☐		Alcohol
☐	☐	☐		Tobacco smoke/chew *(circle one or both)*
☐	☐	☐		E-cigarettes/vapor cigarettes
☐	☐	☐		Marijuana
☐	☐	☐		Narcotics
☐	☐	☐		Stimulants
☐	☐	☐		Methamphetamine
☐	☐	☐		Hallucinogens
☐	☐	☐		Steroids
☐	☐	☐		Huffing
☐	☐	☐		Ecstasy
☐	☐	☐		Street drugs, unknown
☐	☐	☐		Prescription drugs prescribed for another, specify:
☐	☐	☐		Over-the-counter medication, specify:
☐	☐	☐		Other, specify:
Additional Comments:				

Has child been identified as high risk?	☐ Yes ☐ No
Has a Safety Plan been completed on child identified as high risk?	☐ Yes ☐ No ☐ N/A

Birth History (for all children)

Birth Weight:		**Birth Length:**		☐ **Full term or** ☐ **Premature birth (<36 weeks)**		weeks
Did mother receive prenatal care:	☐ Yes ☐ No	**Month of pregnancy for 1st prenatal visit:**				
Pregnancy/Birth complications:						
Was there prenatal substance abuse:	☐ Yes ☐ No	**Substance and frequency:**				
Birth hospital and location:						

Minor Female

Age of 1st Period:		**Date of Last Period:**					
Pregnancies #		**Live births #**		**Full term**		**Premature (# weeks)**	
Miscarriages #		**Abortions #**		**Currently pregnant:**	☐ Yes ☐ No	**If yes, due date:**	

Does the youth have children? ☐ Yes ☐ No If yes, answer below questions:

Youth's Children's Names	DOB	In DCS Custody?	Male/ Female?	Race	Name of Person Child Lives with and Relationship	Name of Child's Other Parent	Contact Information of Other Parent
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or non-binary?	☐ Yes ☐ No
If yes, describe answer	

Sexual Activity

Is child sexually active?	☐ Yes ☐ No	**Use birth control?**	☐ Yes ☐ No	**Method:**	

Dating Violence

Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship?	☐ Yes ☐ No				
If yes, explain:					
Child Name:	Type Here Error! Reference source not found.	**Child DOB:**	Type Here	**Person ID:**	Type Here

Medical

Does the Child/Youth have a regular medical provider (pediatrician, family doctor, etc.)?	☐ Yes ☐ No		
If yes, name of medical provider:		**Date of last visit:**	

Immunizations

Are immunizations up to date?	☐ Yes ☐ No	**Is the immunization record available?**	☐ Yes ☐ No
Religious/medical exemption?	☐ Yes ☐ No (parent/guardian must provide a notarized statement)		

Dental

Does the Child/Youth have a regular dental provider?	☐ Yes ☐ No	**Does the Child/Youth wear braces?**	☐ Yes ☐ No
If yes, name of dental provider:		**Date of last exam:**	
If braces, name of orthodontist:		**Date of last exam:**	

Vision

Does the Child/Youth wear glasses?	☐ Yes ☐ No	**Does the Child/Youth wear contacts?**	☐ Yes ☐ No
If yes, name of vision provider:		**Date of last visit:**	

This concludes the Well-Being Section

Child Name:	Type Here Error! Reference source not found.	Child DOB:	Type Here	Person ID:	Type Here

This information does not go to Health Care Provider

Education and Independent Living

Student graduated high school?	☐ Yes ☐ No ☐ GED ☐ HISET ☐ Student Home Schooled				
What school does the student attend? (name, city, county)					
Student's age		**Current grade**		**Student receives special education services?**	☐ **Yes** ☐ **No**
If yes, name the disability					

No	Yes	
☐	☐	Is the student taking GED classes
☐	☐	Does the student have a history of skipping school?
☐	☐	Is the student in an alternative school?
☐	☐	Is the student serving a zero-tolerance expulsion (drugs, weapons and/or assault)?
☐	☐	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?

Student strengths (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☐ Attendance in school
☐ Other, specify	☐ Other, specify

Other things you would like to share regarding your student's schooling?	

Presenting and Previous Court Actions on Youth (Unruly/Delinquent Youth only)

Current Dispositional Information					
Disposition Judge		**Special Judge**			
Current Disposition Court					
Current Disposition Decision			**Disposition Date**		
Have you been or are you currently on probation?	☐ Yes ☐ No	**If yes, where**			
Defense Attorney					
Current Adjudication Type			**Current Adjudication Date**		

Adjudicated Charge – Current and Previous	**Date Occurred**	**Disposition Date**	**Disposition**

Pending Charges	**Court Date Set**	**Date (if yes)**
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Child Name:	Type Here Error! Reference source not found.	Child DOB:	Type Here	Person ID:	Type Here
Narrative					

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency	
Other *(explain)*	
Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	
B) Domestic Violence	
Narrative	
Strengths *(Signs of Safety)*	
Risks, Needs and Concerns *(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)*	

FSW Name		Contact #	
Office Address			
Supervisor		Contact #	

DCS / Provider Staff *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

Foster Parent *Date*

Foster Parent *Date*

Child Name:	Type Here Error! Reference source not found.	**Child DOB:**	Type Here	**Person ID:**	Type Here

Do not provide this section to the Foster Parent or the Health Care Provider

Has the child/Youth been adopted: ☐ Yes ☐ No**:** **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☐ No
Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☐ No**:** If yes, Amount**:** _____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

Adoption/Guardianship Completed by DCS: ☐ Yes ☐ No (If no List Name of the Agency)

Removal Date:		**New Placement:**		**Date of Placement:**		**Legal Custody Date:**	
Removal County:		**Adjudication Type:** **Brief Description:**	☐ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A				

Removal Reason: ☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other: ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☐ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment; ☐ Sexual Abuse (alleged/reported); ☐ Truancy

Removal Street Address							
City		**County**		**State**		**Zip Code**	
Kinship Exception Request							
Was KER approved?	☐ Yes ☐ No	**If yes, by whom?**					
Was the KER temporary or long term?	☐ **temporary** ☐ **long term**						
MSW Consult was completed with:							

Family Information

Both parents living?	☐ Yes ☐ No	**If no, date(s) of death:**	
Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.			

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name		**Primary Caregiver**	☐ Yes ☐ No
Email Address		☐ Yes ☐ No	

Maiden Name		**Social Security No.**		**DOB**		**Message Contact #**	
Address					☐ Yes ☐ No		
City, State, Zip						**Contact #**	
Employer			**Address**				
City, State, Zip						**Contact #**	

Birth mother married when child/Youth was born?	☐ Yes ☐ No ☐ Unable to Determine				
Birth mother ever been married?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**			
Birth mother ever been divorced?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and from whom?**			
Is there a father listed on the birth certificate?	☐ Yes ☐ No				
Has DNA testing ever been done?	☐ Yes ☐ No	**If so, what were the results and where was it done?**			
Has there ever been a legal father identified (either mother was married at the time of birth or a father has been legitimated through the court)?	☐ Yes ☐ No				
Birth mother's race:					
Legal Father's Name		**Primary Caregiver**	☐ Yes ☐ No		
Email Address		☐ Yes ☐ No			
Social Security No.	**DOB**	**Message Contact #**			
Address	☐ Yes ☐ No				
City, State, Zip	**Contact #**				
Employer	**Address**				
City, State, Zip	**Contact #**				
Legal Father's Race:					
Marital Status of Parents	☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Other**				
Putative/Alleged Father's Name					
Email Address	☐ Yes ☐ No				
Social Security No.	**DOB**	**Message Contact #**			
Address	☐ Yes ☐ No				
City, State, Zip	**Contact #**				
Employer	**Address**				
City, State, Zip	**Contact #**				
Putative/Alleged Father's Race:					
Caregiver's Name *(if different from above)*	**Relationship**				
Email Address	☐ Yes ☐ No				
Social Security No.	**DOB**	**Message Contact #**			
Address	☐ Yes ☐ No				
City, State, Zip	**Contact #**				

Employer		**Address**	
City, State, Zip		**Contact #**	
Relative Contact Person for Child/Youth (other than parent)			
		Contact #	
Relationship			

Child Name:	Type Here Error! Reference source not found.	**Child DOB:**	Type Here	**Person ID:**	Type Here

Child/Youth Siblings:										**In Custody**
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No
Name		**SSN**		**DOB**		**Sex**		**Race**		☐ Yes ☐ No

Tennessee Department of Children's Services

Foster Home Medication Record

Child's Name Type Here **Age** _____ **Month/Year** _____

Foster Parent Name Type Here

Prescription Medication(s) (for psych meds only)

	Name of medication	Dosage	Times given	Prescribing Provider	Next appt. date/time	Informed Consent
1.						☐ Yes ☐ N/A
2.						☐ Yes ☐ N/A
3.						☐ Yes ☐ N/A
4.						☐ Yes ☐ N/A
5.						☐ Yes ☐ N/A

Side effects noted _____

Any changes or improvements noted _____

Any questions for the Provider _____

Phone numbers for Providers _____

Missed or Refused Doses

Medication	Date/time	Reason	Prescriber notified
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____
			☐ Yes ☐ No Date _____

Weekly Medication Counts

	Date	Medication	Amount left	# of Refills	Refill date	Stop date
Week 1						
Week 2						
Week 3						
Week 4						
Week 5						

Additional information _____

_____

_____

Prescription Medication(s) given as needed (PRN)

Name of medication	Dosage	Given for	Prescribing Provider	Approval from DCS*
1.				☐ Yes ☐ No ☐ N/A
2.				☐ Yes ☐ No ☐ N/A
3.				☐ Yes ☐ No ☐ N/A
4.				☐ Yes ☐ No ☐ N/A
5.				☐ Yes ☐ No ☐ N/A

Side effects noted _____

Any changes or improvements noted _____

Any questions for the Provider _____

Phone numbers for Providers _____

Over-the-Counter Medication(s)

Name of medication	Dosage	Given for	OK'd by Prescribing Provider	
1.			☐ Yes ☐ No	Provider name
2.			☐ Yes ☐ No	Provider name
3.			☐ Yes ☐ No	Provider name
4.			☐ Yes ☐ No	Provider name
5.			☐ Yes ☐ No	Provider name

Side effects noted _____

Any changes or improvements noted _____

Any questions for the Provider _____

Reviewed by (case mgr signature) _____ ☐ DCS ☐ Contract provider

Print name _____ Date _____

Name of contract provider if appliable _____ Copy to DCS FSW ☐

Tennessee Department of Children's Services

Database Search Results

This form is to be used to request a search of the DCS current child welfare information system database. This request must be typewritten and must be completed for all prospective foster parents, DCS and provider employees who will work with children, and proposed conservators per *policy 19.10*. NOTE: Requests should be submitted only by persons who are completing foster home studies, persons responsible for completing child protective history search information for prospective employees, or FSWs with a conservatorship case. This form needs to be submitted in WORD format.

Date of Request: / /

Name: Enter Name of Person Making the Request	**Agency:**	
Email:	**Telephone:**	**Fax:**
Street Address:		
City:	**State:**	**Zip Code:**
Enter applicant's full name. Include in parentheses maiden name, all alias names, and all alternate last names.		
Full Name: Enter Name of Person Being Researched	**Release on file with Agency:**	
Address:		
Telephone:	**Social Security Number: - -**	**Date of Birth: / /**
Reason for Search Request:	**Specify (if other):**	
Request Category:	**If "Recheck Request" explain reason recheck is needed:**	

Section below to be completed by DCS ONLY

The following is the database search results for the above referenced person:

☐	**No evidence was found indicating that the person listed above is substantiated as a perpetrator of child abuse or neglect in Tennessee.**
☐	**DCS was unable to complete your request at this time. Final results may take 30-60 days.**
☐	**The results are inconclusive; More specific information is needed to accurately process your request.**
☐	**Database search records show that the above-listed person is substantiated by DCS for in Tennessee.**
☐	**The above listed person has not been substantiated by DCS or allegations substantiated against the person occurred more than 2 years ago, with no further action taken. Therefore, its release is prohibited by Tennessee Comprehensive Rules & Regulations 0250-7-9-.03(5).**

Search completed by:	**Date:**

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Case File (Personnel, Foster Home as applicable)

Tennessee Department of Children's Services

Background Criminal History-Expedited/Emergency Purpose Code X III Name Check

(For Expedited/ Emergency Placements) Date: _____

Please Print Clearly.

RE: Background Clearance Checks:

The Department of Children's Services is conducting an expedited/emergency placement of a child(ren) under exigent circumstances on the individual named below. The approval of the application requires a criminal history background check prior to the person being approved as a placement for children.

Name(s) _____ Birth Name _____
Married Name: _____ Alias: _____
Gender: _____ Race: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

Please Check Appropriately.

☐ Previous Arrest Record: _____ (Record attached): _____

☐ No Previous Arrest Record: _____

Signature of Records Clearance Officer: _____ Date: _____
Please Return Response to: _____
Address: _____

Telephone: _____ Fax: _____

Verification of Fingerprint Completion within Fifteen (15) days.

_____ _____
FSW Signature Date

_____ _____
Supervisor Signature Date

Tennessee Department of Children's Services

Foster Home Disaster Plan

Foster Home Name: Type Here

This document contains my plans if I am required to leave my home address due to a natural disaster or catastrophic event.

If I need to evacuate my home, I will relocate to:

FIRST CHOICE: (*name of friend or family if relocating to a residence, address, phone number, alternate phone number, other contact information – email, other*):

Name | *Address*

( ) - | ( ) - | *Other Contact Information*

Telephone No. | *Alternate Telephone No.*

If I am not able to go there, my **SECOND CHOICE** would be: (*address, phone number, alternate phone number, other contact information – email, other*):

Name | *Address*

( ) - | ( ) - | *Other Contact Information*

Telephone No. | *Alternate Telephone No.*

Other means of contacting me: ( ) - *Cell Phone Number* | *E-Mail Address*

Contact information for persons who I would be in touch within case of an emergency and who Department of Children's Services (DCS)/Provider could contact if necessary (*e.g.*, *family member or friend, living outside of the immediate area, etc.*):

Name | *Address* | ( ) - *Telephone No.*

Name | *Address* | ( ) - *Telephone No.*

Other information:

I understand that there are critical items I am urged to take with me when we evacuate. These include:

- DCS/Provider contact information (*e.g., Family Service Worker and emergency contact numbers*);
- My children's medical information (*e.g., prescriptions, recent medical records, physician's name and contact information and immunization history).*
- Educational records.
- Identifying information for the child including citizenship information; and
- Court order giving DCS custody of any children in my home at the time of the event.

I understand that I am required to check in with DCS/Provider. I can use these telephone numbers:

( ) - | ( ) - | ( ) -

I understand that should any of the information included in this plan change that I am to update this form within fourteen (14) days of the change and provide DCS/Provider with the update.

Signature | *Date*

Print Name

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: Foster Home Case File, Foster Parent

Tennessee Department of Children's Services

Waiver of Criminal Convictions, Pre- and In-Service Training Requirements, Non- Safety Issues, CPS Substantiations and Education Requirements

Requesting Agency/DCS Region: _____ **Telephone No.:** ( ) -

Employee/Foster Home Name: _____

Household Member Requiring Waiver: _____

Household Member Address: _____

Household Member Phone Number: _____ **Email Address (Training Only)** _____

Type of Waiver: ☐ **Education** ☐ **Misdemeanor Conviction** ☐ **Felony Convictions**

☐ **CPS Substantiation** ☐ **Non-Safety Issue** ☐ **Excess of 5 Conviction** ☐ **Training**

☐ **Pre-Service Training** ☐ **In-Service Training**

☐ Extension ☐ Equivalent ☐ Individual ☐ ICPC Condensed (Relative/Kin Only)

☐ Deferred ☐ Exemption ☐ Deferred ☐ Modified Schedule

☐ Medical Resources and Information Modification (Medical Professional Only)

☐ CPR/First Aid

Expiration Date for CPR/First Aid Equivalent: _____ (to be entered by Central Office staff at time of approval)

Criminal History: (if more space is needed, please add to the justification section)

Date of Conviction	Type of Conviction	Description of Conviction	County/State	Comments
	Misd ☐ Felony ☐			
	Misd ☐ Felony ☐			
	Misd ☐ Felony ☐			
	Misd ☐ Felony ☐			
	Misd ☐ Felony ☐			
	Misd ☐ Felony ☐			

Employee/Foster Home/Household Member Name: _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: DCS Foster Home Case file, Employee, Personnel file, Private Provider Case File, CPS Case File

CPS Substantiation:

Date of Substantiation	Allegation Type Substantiated	Severe (Y/N)	County/State

Provide details regarding the circumstances and justification of the waiver request. Describe how the matters have been resolved or are no longer a safety issue. (Attach supporting documentation such as criminal history, juvenile court orders, DCS hearing orders, CPS notices, or supporting training documentation which could further support the request). List additional criminal history that would not fit above in this section, if needed:

For Non-Custodial Placements, Foster Homes and Employees:

☐ **Approved**
☐ **Denied**

_____ _____

Regional Director /Designee Signature ***Date***

☐ **Approved**
☐ **Denied**

_____ _____

Contract Agency Executive Director/Designee Signature ***Date***

☐ **Approved**
☐ **Denied**

_____ _____

Executive Director of Child Programs/Designee Signature ***Date***

☐ **Approved**
☐ **Denied**

_____ _____

Director of Licensure/Designee Signature ***Date***

For Training Exceptions:

☐ **Approved**
☐ **Denied**

_____ _____

Director of Training and Professional Development/Designee Signature ***Date***

☐ **Approved**
☐ **Denied**

_____ _____

Director of Health Advocacy/Designee Signature ***Date***

Employee/Foster Home/Household Member Name: _____

For DCS Employees Only:

☐ **Approved**
☐ **Denied**

Executive Director of Human Resources/Designee Signature ***Date***

☐ **Approved**
☐ **Denied**

Commissioner/Assistant or Deputy Commissioner/Designee ***Date***

For CPS Substantiations:

☐ **Approved**
☐ **Denied**

Executive Director Child Safety/Designee Signature ***Date***

Tennessee Department of Children's Services

Waiver Agreement and Statement for Criminal History Checks

This form must be completed and signed by every current or prospective employee, volunteer, contractor/vendor, and foster/adoptive parent for whom criminal history records are requested by a qualified entity.

I hereby authorize _____ to submit a set of fingerprints through the TBI vendor and this form to the Tennessee Bureau of Investigation (TBI), for the purpose of accessing and reviewing Tennessee and national criminal history that may pertain to me directly from the FBI, pursuant to 28 CFR, Sections 16.30-16.34. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be a **child care provider** (employee, volunteer, contractor or foster/adoptive parent).

I understand that, until the criminal history background check is completed, you may choose to deny me unsupervised access to entity locations. I further understand that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or foster/adoptive parent.

A national criminal history background check on me is being requested by _____

Address: _____

City: _____ State: _____ Zip: _____

I have ☐ OR have not ☐ been convicted of a crime. PLEASE CHECK ONE
If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:

I am a current or prospective (check one): Employee ☐ Volunteer ☐ Contractor/Vendor ☐
Foster/Adoptive Parent ☐

Signature: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth Required: _____

I have been given a copy of the **Applicant's Policy Rights**: _____
Applicant's Signature

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- You must be provided written notification1 that your fingerprints will be used to check the criminal history records of the FBI.

- You must be provided, and acknowledge receipt of, an adequate Privacy Act Statement when you submit your fingerprints and associated personal information. This Privacy Act Statement should explain the authority for collecting your information and how your information will be used, retained, and shared.[2]

- If you have a criminal history record, the officials making a determination of your suitability for the employment, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.

- The officials must advise you that the procedures for obtaining a change, correction, or update of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.

- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the criminal history record.[3]

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[4]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https://www.fbi.gov/services/cjis/identity-history-summary-checks

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

[1] Written notification includes electronic notification but excludes oral notification.

[2] See http://www.fbi.gov/services/cjis/compact-council/privacy-act-statement

[3] See 28 CFR 50.12(b).

[4] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).

AGENCY PRIVACY REQUIREMENTS FOR NONCRIMINAL JUSTICE APPLICANTS

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint- based criminal history record check on an applicant for a noncriminal justice purpose (such as employment or a license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notice and other information and that the results of the check are handled in a manner that protects the applicant's privacy. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28, Code of Federal Regulations (CFR), Section 50.12, among other authorities.

- Officials must provide to the applicant written notification11 that his/her fingerprints will be used to check the criminal history records of the FBI.
- Officials must ensure that an applicant receives, and acknowledges receipt of, an adequate Privacy Act Statement when the applicant submits his/her fingerprints and associated personal information.[2]
- Officials using the FBI criminal history record (if one exists) to decide of the applicant's suitability for the employment, license, or other benefit must provide the applicant the opportunity to complete or challenge the accuracy of the information in the record.
- Officials must advise the applicant that procedures for obtaining a change, correction, or update of an FBI criminal history record are set forth at 28 CFR 16.34.
- Officials should not deny the employment, license, or other benefit based on information in the criminal history record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.
- Officials must use the criminal history record solely for the purpose requested and cannot disseminate the record outside the receiving department, related agency, or other authorized entity.[3]

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, this courtesy will save the applicant the time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found at 28 CFR 16.30 through 16.34. It will also allow the officials to make a timelier determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant notice, what constitutes "a reasonable time" for the applicant to correct or complete the record, and any applicant appeal process that is afforded the applicant. Such documentation will assist State and/or FBI auditors during periodic compliance reviews on use of criminal history records for noncriminal justice purposes.

[1] Written notification includes electronic notification but excludes oral notification.

[2] See https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement

[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), 50.12(b) and 906.2(d).