Wheeler

Innovative Care. Positive Change.

Date: _____

Parent 1

Name: _____

Date of Birth: _____

Nationality and Place of

Birth:_____

US Citizen:

If no please explain:_____

Email: _____

Phone (home):_____

Phone (cell):_____

Phone (work):_____

Occupation:_____

Employer: _____

Employment status:

Work Hours:_____

Highest Education Level:_____

Military Service:

If yes please explain:_____

Religious Affiliation:_____

Martial Status: Single ☐ Married ☐
Divorced ☐ Widow ☐ Separated ☐
In a Relationship ☐

Marriage Date:_____

Previous Marriages (dates and reason for termination):_____

_____

Driver's License:

Auto Insurance:

Parent 2

Name: _____

Date of Birth: _____

Nationality and Place of

Birth:_____

US Citizen:

If no please explain:_____

Email: _____

Phone (home):_____

Phone (cell):_____

Phone (work):_____

Occupation:_____

Employer: _____

Employment Status:

Work Hours: _____

Highest Education Level:_____

Military Service:

If yes please explain:_____

Religious Affiliation:_____

Martial Status: Single ☐ Married ☐
Divorced ☐ Widow ☐ Separated ☐
In a Relationship ☐

Marriage Date:_____

Previous Marriages (dates and reason for termination):_____

_____

Driver's License:

Auto Insurance:

Family/Household Information

Address:

Housing: How Many Bedrooms: _____

Pets:

If yes, what type/breed:

Check all that apply to your home (do you have?):

Pool ☐ Hot Tub ☐ Public Water Supply ☐ Well Water Supply ☐

Wood Stove ☐ Fireplace ☐ Coal Heat ☐ Gas Heat ☐ Oil Heat ☐

Smoke Detectors ☐ Carbon Monoxide Detectors ☐

Is your home lead free:

Other household members:

Name	Date of Birth	Birthplace	Age	Relationship to Parent 1 or Parent 2	School/ Employed/ Military/Other

Adult Children (outside the home):

Name	Date of Birth	Birthplace	Age	Relationship to Parent 1 or Parent 2	School/ Employed/ Military/Other

Do you, your adult children, anyone that frequents the home or any household members have a medical condition or mental health issue: If yes, who and what:

Do you, your adult children, anyone that frequents the home or any household members own or use firearms and/or dangerous weapons: If yes, who and what:

Do you, your adult children, anyone that frequents the home or any household members have a criminal and/or child protective history: If yes, who and what:

Have you ever foster or adopted before:

If so when and with what agency: _____

How did you here about our program: Facebook ☐ Wheeler Clinic Website ☐ YouTube ☐

Event ☐ Newspaper ☐ Friend ☐ Radio ☐ Other_____

How long have you been thinking about becoming a foster parent? _____

Do you have a preferred age or gender of foster child:

If yes please describe: _____

References

(Must have 3 listed, they will only be contacted if you are accepted as an applicant)

Name	
Mailing Address	
Phone Number	
Relationship to Applicant	
Best method of contact	Phone Call ☐ Mail ☐

Name	
Mailing Address	
Phone Number	
Relationship to Applicant	
Best method of contact	Phone Call ☐ Mail ☐

Name	
Mailing Address	
Phone Number	
Relationship to Applicant	
Best method of contact	Phone Call ☐ Mail ☐

Signatures

By initialing below you are confirming that all the information provided above is the true to the best of your knowledge.

Parent 1

Name:_____

Initial:_____

Date:_____

Parent 2

Name:_____

Initial:_____

Date:_____

To submit please use one of the following methods:
Email- Attach file to Email and send to FosterCarePrograms@Wheelerclinic.org
Fax- Send completed form to 860-793-4468 ATTN Foster Care Program
Mail- Send completed form to ATTN Foster Care Program, 88 East St, Plainville CT, 06062

Wheeler Clinic Staff Use Only

Phone Interview: _____ Face to Face Interview: _____
Application Given: _____ Application Received: _____ Attended OH: _____
Informational Packet Given: _____ ROI:_____ Training Session: _____
HIPPA: _____ Date of Initial Contact:_____ Recruiter:_____