Lii Michif Otipemisiwak Family and Community Services
707 Tranquille Road, Kamloops, BC • V2B 3J1
Tel: (250) 554-9486 Fax: (250) 554-9487

CAREGIVER APPLICATION FORM

INSTRUCTIONS:
If you are filling out this form by hand, please print clearly using ink pen. If you cannot find enough space to include all of you responses to any of the questions on this form, please place on a separate piece of paper and attach it to this application. Once you have completed this form, return it to your Resource Worker.

PART 1
APPLICANT #1

FULL NAME	ALSO KNOWN AS (INCLUDING MAIDEN NAME IF APPLICABLE)	DATE OF BIRTH(YYYY/MM/DD)
PLACE OF BIRTH	ETHNIC ORIGIN	LANGUAGES SPOKEN
DO YOU CONSIDER YOURSELF ABORIGINAL ☐ YES ☐ NO	IF YES, IDENTIFY YOUR ABORIGINAL CULTURAL GROUP OR FIRST NATION	SOCIAL INSURANCE NUMBER

APPLICANT #2

FULL NAME	ALSO KNOWN AS (INCLUDING MAIDEN NAME IF APPLICABLE)	DATE OF BIRTH(YYYY/MM/DD)
PLACE OF BIRTH	ETHNIC ORIGIN	LANGUAGES SPOKEN
DO YOU CONSIDER YOURSELF ABORIGINAL ☐ YES ☐ NO	IF YES, IDENTIFY YOUR ABORIGINAL CULTURAL GROUP OR FIRST NATION	SOCIAL INSURANCE NUMBER

ADDRESS

HOME ADDRESS	CITY/TOWN	POSTAL CODE
MAILING ADDRESS (IF DIFFERENT)	CITY/TOWN	POSTAL CODE
DIRECTION TO HOME IF NEEDED		
AREA CODE AND HOME PHONE NUMBER	AREA CODE & WORK PHONE (APPLICANT #1)	AREA CODE & WORK PHONE NUMBER (APPLICANT #2)

INFORMATION REGARDING CHILDREN AND EXTENDED FAMILY MEMBERS

NAME	GENDER M/F	BIRTHDATE YYYY/MM/DD	RELATIONSHIP	LOCATION

Have any of your children ever been placed in foster/family care, treatment or correctional resource?

☐ YES ☐ NO IF YES:_____

FOSTER/FAMILY CARE

WITH WHOM	WHERE	DATE(S) (YYY/MM/DD)

OTHER RESOURCE

NAME OF RESOURCE	WHERE	DATE(S) (YYY/MM/DD)

OTHER PERSONS IN YOUR HOME (e.g., boarders, daycare children other than own children)

NAME	GENDER M/F	AGE	RELATIONSHIP	DAY CARE OR RESIDENT

PART II
MARITAL/OTHER RELATIONSHIP

LEGAL RELATIONSHIP OF APPLICANT TO EACH OTHER	DATE OF MARRIAGE OR LENGTH OF LEGAL RELATIONSHIP

RELIGION/SPIRITUAL VALUES/BELIEF SYSTEM

Describe your religion/spiritual values/belief system:

APPLICANT #1	APPLICANT #2

EDUCATION AND EXPERIENCE (including date(s) when completed)

APPLICANT #1

EDUCATION COMPLETED	SPECIAL TRAINING
FAMILY /CHILD CARE RELATEED COURSES TAKEN	
SPECIAL EXPERIENCE RELATED TO FAMILY CARE	

APPLICANT #2

EDUCATION COMPLETED	SPECIAL TRAINING
FAMILY /CHILD CARE RELATEED COURSES TAKEN	
SPECIAL EXPERIENCE RELATED TO FAMILY CARE	

EMPLOYMENT/OCCUPATION

APPLICANT #1		APPLICANT #2	
PRESENT EMPLOYMENT/OCCUPATION		PRESENT EMPLOYMENT/OCCUPATION	
LENGTH OF PRESENT EMPLOYMENT/OCCUPATION	PART TIME/FULL TIME	LENGTH OF PRESENT EMPLOYMENT/OCCUPATION	PARTTIME/FULLTIME

FAMILY'S APPROXIMATE GROSS YEARLY INCOME
$

CHILD CARE ARRANGEMENTS

IF APPLICANT(S) IS/ARE WORKING, DESCRIBE CHILD CARE ARRANGEMENTS FOR YOUR PRESCHOOL AND SCHOOL AGED CHILDREN

FAMILY GROUP AND INDIVIDUAL INTERESTS, ACTIVITIES, HOBBIES (Please list)

1.	5.
2.	6.
3.	7.
4.	8.

HEALTH HISTORY OF APPLICANTS AND HOUSEHOLD MEMBERS

1. Are all family and household members in good health ☐ YES ☐ NO
2. List members who have been treated for serious health issues, disabilities, or long term conditions.

NAME	CONDITION
NAME	CONDITION
NAME	CONDITION
NAME	CONDITION

3. List members who have been seen or counseled for emotional or mental health problems (by psychologist, psychiatrist, ministry worker, or mental health clinic).

NAME	SEEN BY	WHERE	WHEN
NAME	SEEN BY	WHERE	WHEN
NAME	SEEN BY	WHERE	WHEN

4. Doctors used by family (please list)

DOCTORS NAME	ADDRESS	POSTAL CODE	TELEPHONE	FAMILY MEMBER'S NAME
			( )	
			( )	
			( )	

APPLICANT #1

Have you ever applied to foster before? ☐ YES ☐ NO IF YES, PLEASE LIST ALL OCCASIONS.

WHERE	DATE(S) (YYY/MM/DD)

APPLICANT #2

Have you ever applied to foster before? ☐ YES ☐ NO IF YES, PLEASE LIST ALL OCCASIONS.

WHERE	DATE(S) (YYY/MM/DD)

TYPE OF CHILD CARE FOR WHOM YOU COULD PROVIDE CARE.

☐ Male or Female ☐ Male ☐ Female	AGE RANGE	NUMBER OF CHILDREN

ARE YOU OPEN TO TAKING CHILDREN OF A RACIAL/CULTURAL ORIGIN OTHER THAN YOUR OWN? (PLEASE SPECIFY)

Sibling group of up to _____children.

Children with Special Needs ☐ YES ☐ NO

If YES, PLEASE INDICATE THE TYPE OF SPECIAL NEEDS YOU CAN PROVIDE CARE FOR	EXTENT OF SPECIAL NEEDS
☐ DEVELOPMENTAL ☐ BEHAVIOURAL ☐ PHYSICAL	☐ MILD ☐ MODERATE ☐ MILD

TYPE OF PLACEMENT DESIRED

☐ EMERGENCY (UP TO 30 DAYS) ☐ RESPITE/RELIEF ☐ SHORT TERM(UP TO ONE YEAR) ☐ LONG TERM(1 YEAR PLUS)

WHY WOULD YOU LIKE TO PROVIDE CARE TO SOMEONE ELSE'S CHILDREN? PLEASE COMMENT.

HOME

TYPE OF ACCMMODATION (HOUSE, APARTMENT, FARM, ETC	PROPOSED SLEEPING ARRANGEMENTS FOR CHILD IF PLACED

PART III
REFERENCES

Please list names and addresses of four persons, including one relative.
These persons must know you well enough to answer questions about your family.

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

NAME	RELATIONSHIP	TELEPHONE NUMBER ( )
ADDRESS	CITY/TOWN	POSTAL CODE

I DECLARE THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND BELIEVE THAT I HAVE NOT OMITTED INFORMATION REQUESTED.

SIGNED	DATE(YYYY/MM/DD)	SIGNED	DATE (YYYY/MM/DD

PLEASE RETURN THIS FORM TO YOUR RESOURCE WORKER