

Non-Primary Application

Non-Primary Applications are completed for individuals who wish to provide care for children living in Family Foster Homes or are 18 years+, and reside in the foster facility. Non-primaries are individuals who are not licensed by DFS as foster parents, but rather, are individuals who have been approved to provide temporary care for children living within a Family Foster Home. This application is to be completed by the individuals seeking DFS clearance.

Make Copies as Necessary.

Date Submitted:
Date Approved:
Date Denied:

Application for Non-Primary Foster Care

Attachments:

NOTE: (Non-Primaries in the company foster children, or 18 years of age or older residing part-time or full time in the home of the foster parent(s) are required to complete a Non Primary Application, provide copies of current driver’s license, auto insurance (if driving a foster child), TB test results, Social Security card, and must set up a finger print appointment with the assigned Licensing Worker. Prints are \$45.00 case, credit card, money order.)

APPLICANT WILL PROVIDE SERVICES TO: _____
Name of Primary Foster Home (Primary Licensee)

Applicant’s Last Name: _____ First: Alias: _____

Address (physical): _____ Telephone: _____

Address (mailing): same Telephone: same

SSN _____ DOB: _____ Place of Birth: _____

RESIDENCE:

List the addresses where you have resided the last five years. Include the name of the county, if possible.

Street	City	State/Zip	County	Dates To/From

REFERENCES: Please list at references that have known you for at least three years. No more than two of the seven may be relatives.

Please be sure to include name, full mailing address including zip code. At least 5 completed references are required.

Name	Relationship	Phone	Mailing Address, Phone and Cell#, email address (please include zip codes)

EMPLOYMENT:

Employed by: _____ Phone: _____ Type of work: _____
 Hours of work: _____ Length of time on present job: _____

TRANSPORTATION:

Non-primary staff may be responsible for providing transportation to counseling, medical appointments, visits with natural parents etc.
 Will you transport? YES NO

If No, Explain _____

Do you have Automobile Insurance? YES NO

Please attach a copy of your Drivers License and DMV record if providing transportation.

Vehicles:

_____	Seat Belts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Car Seats: <input type="checkbox"/> Yes <input type="checkbox"/> No
Year Make Registration Dates		
_____	Seat Belts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Car Seats: <input type="checkbox"/> Yes <input type="checkbox"/> No
Year Make Registration Dates		

Other Transportation Available: _____

BACKGROUND INFORMATION:

I. Have you ever been licensed as a foster home in Nevada or in another State or worked in a Foster/Group Home?

Yes No If Yes, when, where and how long? _____

II. Do you now or have you ever provided care for any child that is not your own? Yes No

If yes, for whom, when, where, & how long? _____

III. Do you now or have you ever had a Child Day Care License? Yes No

If yes, please list the state(s) and when you possessed the license(s). If you have a current child care license, please attach copy of the license. _____

IV. Give a brief statement as to your reasons for being in the same home as our foster children foster children: _____

V. List your special qualities, talents, hobbies, additional language spoken, etc.: _____

III. Describe your general health (include any serious illnesses or disabilities): _____

VI. a Do you have any history of mental illness, drug or alcohol addiction? Yes No

If yes, explain: _____

VII. Are you or have you ever been on any medications? Yes No If yes, table below must be completed. Please exclude medications prescribed to treat common childhood illness such as flu, ear, infections, etc.

MEDICATION	DOSAGE	PRESCRIBED BY	DATE STARTED & DISCONTINUED

VIII. Have you ever been arrested? Yes No

Date fingerprints submitted to the Department of Family Services: (call Background Dept. if you need to cancel or change your appointment 702-455-5146) _____

If yes, please explain: _____

Yes No If yes, list name, date, investigating agency where incident occurred, allegations and outcome of case: _____

(cont. if needed)

- In any case in which a record check reveals a felony conviction for child abuse or neglect, for spousal abuse, for a crime against children (including child pornography), or for a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery, if a State finds that a court of competent jurisdiction has determined that the felony was committed at any time, such final approval shall **not** be granted; and
- In any case in which a record check reveals a felony conviction for physical assault, battery, or a drug-related offense, if a State finds that a court of competent jurisdiction has determined that the felony was committed within the past 5 years, such final approval shall **not** be granted.

I attest that the above information is complete and true to the best of my knowledge. Failure to disclose or answer the questions truthfully may result in an immediate denial of this application.

Signature

Date

Release of Information
(Non-primary application)

Regarding:

Name Applicant #1

Social Security Number

Name Applicant #2

Social Security Number

You are authorized by the undersigned to release to the Department of Family Services, the information including, but not limited to, that indicated below. This authorization constitutes a full and complete release from any liability resulting from disclosure of such information. This authorization also permits release of medical information under the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255) and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act amendments of 1974 (P.L. 93-282). A photocopy of this form shall be as valid as the original.

Data Requested:

Signature Applicant #1

Date

Signature Applicant #2

Date

