

NOTICE OF FORM CHANGE NO. 04-217

DATE

07/27/2004

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

Community Care Licensing District Offices
 Private and Public Adoption Agencies

District Attorney
 Other County Probation Departments

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

FORM NUMBER AND TITLE SOC 815 (7/04) Approval of Family Caregiver Home

ORDER UNIT MASTER ONLY	<input checked="" type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> New <input checked="" type="checkbox"/> Revised	DATE OF FORM 7/04	REPLACES 11/02	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input checked="" type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: Department of Social Services Warehouse P.O. Box 980788 West Sacramento, CA 95798-0788		<input type="checkbox"/> Other:	

FORMS DISPOSITION AND SPECIAL INSTRUCTIONS

DISPOSITION OF OLD SUPPLY

Use until exhausted Destroy

USE NEW FORM

When supply available in DSS Warehouse Use new form effective 7/1/04.

USE FORM IN ACCORDANCE WITH

All County Letter No.
 Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE

Attached is a Reproducible Copy

8-1/2" x 11", 4 page form.

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

Child's Name: _____ Case Number: _____
Child's SSN: _____ DOB: _____
Caregiver Name: _____

Approval of Family Caregiver Home

Pursuant to the provisions of WIC Section 319, I certify that I assessed

_____ Name

_____ Address

the Relative NREFM _____
Relationship to child
of _____; and
Child's Name Social Security Number DOB

the Relative NREFM _____
Relationship to child
of _____; and
Child's Name Social Security Number DOB

the Relative NREFM _____
Relationship to child
of _____
Child's Name Social Security Number DOB

1. CRIMINAL RECORD/ PRIOR ABUSE CLEARANCES

Criminal Record and Child Abuse records have been checked for the caregiver(s), all adults living in the home or on the premises, and other non-exempt person(s) who have routine contact with the child(ren).

- ALL ADULTS CLEARED
 NOT CLEARED

2. CAREGIVER QUALIFICATIONS

- The above named prospective caregiver has been assessed as able to care for and supervise the above named child(ren) and provide for the child(ren)'s special needs; Caregiver Assessment completed and attached.
 CAREGIVER NOT QUALIFIED.

3. SAFETY OF THE HOME AND GROUNDS

- An on-site inspection of the home's building and grounds was conducted on _____ by _____
(Date) (Name)
 The home is clean, safe, sanitary and in good repair for the safety and well-being of the child(ren), meeting required licensing/approval standards set forth in MPP 31-445.3; Checklist of Health and Safety Standards completed and attached.
 HOME DOES NOT MEET APPROVAL STANDARDS.

Child's Name: _____ Case Number: _____
Child's SSN: _____ DOB: _____
Caregiver Name: _____

4. CHILD'S PERSONAL RIGHTS

Information regarding the personal rights of foster children has been provided to the prospective caregiver who has agreed to provide a copy of that information to any child (or the child's authorized representative where applicable) placed in his or her home.

5. COMPLETION OF ORIENTATION/TRAINING

The caregiver has received a summary of State approval regulations and completed the orientation provided by the county.

<input type="checkbox"/> I certify that the above named caregiver meets the standards for relative or non-relative extended family member home approval as of _____. (Date)	
<input type="checkbox"/> I certify that as of _____ the above named (Date) caregiver meets the standards for relative or non-relative extended family member home approval pending completion of the Plan of Correction.	
<input type="checkbox"/> Plan of Correction completed on _____. (Date)	
<input type="checkbox"/> Plan of Correction not completed by agreed due date.	
<input type="checkbox"/> I certify that the above named caregiver DOES NOT meet the standards for relative or non-relative extended family member home approval as of _____. (Date)	
_____	_____
Assessment Approval Worker's Signature	(Date)

Assessment Approval County	
_____	_____
Supervisor's Signature	(Date)

Child's Name: _____ Case Number: _____
 Child's SSN: _____ DOB: _____
 Caregiver Name: _____

CRIMINAL BACKGROUND CHECKS

	CLETS	CWS/CMS Search	Live Scan Fingerprints Submitted	LIVE SCAN Received	DOJ CACI Received	FBI Requested	FBI Received	Exemption Requested	Exemption Granted	Exemption Denied	DOJ RAP-Backs Requested
Caregiver:	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)	(Date)
Other Adults											

Child's Name: _____ Case Number: _____
 Child's SSN: _____ DOB: _____
 Caregiver Name: _____

Checklist of Standards for Approval of Family Caregiver Home

Pursuant to Division 31, MPP Section 31-445.3, in order to be approved, all Foster Care Homes must meet the following standards, set forth in Title 22, Division 6, Chapter 9.5, Article 3.

Section	STANDARD	YES	NO	DAP*	CAP
89317	APPLICANT QUALIFICATIONS				
89319	CRIMINAL RECORD CLEARANCE REQUIREMENT				
89323	EMERGENCY PLAN				
89361	REPORTING REQUIREMENTS				
89370	CHILDREN'S RECORDS				
89372	PERSONAL RIGHTS				
89373	TELEPHONES				
89374	TRANSPORTATION				
89376	FOOD SERVICE				
89378	RESPONSIBILITY FOR PROVIDING CARE & SUPERVISION				
89379	ACTIVITIES				
89387	BUILDINGS AND GROUNDS				
89387.1	OUTDOOR ACTIVITY SPACE				
89387.2	STORAGE SPACE				
89388	COOPERATION & COMPLIANCE				

*DAP: DOCUMENTED ALTERNATIVE PLAN MADE

CAP: CORRECTIVE ACTION PLAN MADE