DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINISTRATION
194 Hernan Cortez Ave, Ste 309 Hagatña, Guam 96910
Telephone: (671) 475-2653/2672 Facsimile: (671) 477-0500

APPLICATION FOR LICENSE:

FAMILY FOSTER HOME (1-6 Children)

A. NAME OF APPLICANT(S):_____
(name to appear on license)

Residential Address:_____

_____

Mailing Address:_____

_____

Telephone Number: Work: _____ Home: _____ Cell: _____
Work: _____ Home: _____ Cell: _____

Email address: _____

B. NUMBER OF CHILDREN TO BE GIVEN CARE: _____

C. AGE RANGE: _____TO_____

D. GENDER: ☐ MALE ONLY ☐ FEMALE ONLY ☐ MALE AND FEMALE

E. DURATION: ☐FULL TIME ☐ EMERGENCY FOSTER CARE (Specify period of care):
_____

F. Are you a permanent resident of Guam? (If not, how long do you plan to stay on Guam?)

☐ Yes ☐ No (Duration on Guam):_____

G. If you have been on Guam for less than 5 years, please provide past addresses in the last 5 years:

Duration of residency	Address

H. Have you previously been license to care for children? ☐ Yes ☐ No

City	State	Dates of licenses

_____ _____ _____
PRINT NAME SIGNITURE DATE

_____ _____ _____
PRINT NAME SIGNITURE DATE

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MEDICAL HISTORY REPORT

Note: This form is to be completed and certified by a physician. Please type or print legibly in black or blue ink.

Name:_____ Date of Birth: _____
(Last Name) (First Name) (M.I.)

Gender: ___ Ht: ___ Wt: ___ Eye Color: ____ Hair Color: ____ Body Mass Index (BMI): _____

Physician's Name:	Tel No:
Name and Address of Clinic:	

PERSONAL HISTORY: Please check all medical conditions below that apply:

	Medical Condition	Past Medical History	Current Medical Condition	For every medical condition checked, briefly describe. *(Please specify the item number of the condition being described. Use the back of paper if additional space is needed).*
1	Diabetes			
2	High Blood Pressure			
3	Cancer			
4	Tuberculosis			
5	Heart Disease			
6	Hepatitis			
7	Auto-Immune Disorder			
8	Depression			
9	Anxiety			
10	Kidney Disease			
11	Skin Disease			
12	Seizure Disorders			
13	Mental Illness			
14	Stomach/Intestinal Disorders			
15	Head Injuries			
16	Fractures			
17	Hearing Impairment			
18	Vision Impairment			
19	Thyroid Disease			
20	Lung Disease			
21	Asthma			
22	Allergies			
23	Organ Transplant			
24	Stroke			
25	Pacemaker			
26	Degenerative Muscular Disorder			
27	Other(s):			

Please answer Yes or No on the questions below. If "Yes", provide your comment on the space provided:

	Yes	No	If yes, please specify (i.e., type, frequency, duration, etc).
Currently taking medication(s)?			
Any history of/current tobacco use?			
Any history of/current alcohol use?			
Any history of/current drug use?			

PHYSICIAN'S CERTIFICATION

I certify that this individual is: [ ] Free from infectious diseases, in good health and able to provide care to a child

[ ] In poor health and unable to provide care to a child

_____ _____
Physician's Signature Date

Revised: 11/19/2009

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GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

LEO G. CASIL
ACTING DIRECTOR

BUREAU OF SOCIAL SERVICES ADMINISTRATION
DIVISION OF PUBLIC WELFARE

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

This information is to be released from records whose confidentiality is protected by Federal law regarding right to privacy, which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information will not be sufficient for this purpose.

1. Name of Program to Give Information: DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES, CHILD PROTECTIVE SERVICES
2. Name of Person or Organization to Receive Information: DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES, HOME EVALUATION & PLACEMENT SERVICES
3. Name of Client (Print Name):
4. Purpose or Need for the Disclosure (Please be very specific): VERIFICATION OF ANY REFERRALS OF CHILD ABUSE/NEGLECT ON THE INDIVIDUAL
5. Extent or Nature of Information to be Disclosed (Please be very specific): OUTCOME OF INVESTIGATION, INCLUDING FINDINGS AND RECOMMENDATIONS, IF APPLICABLE

The client may revoke this Consent for Disclosure of Client Information at any time.

This Consent shall be effective immediately and shall remain in effect until (date): _____

_____ Signature of Client/Guardian/Parent Date: _____	_____ Signature of Person Requesting Information Date: _____

I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE PERSON OR ORGANIZATION ABOVE AS OF: _____

_____ Signature of Client/Guardian/Parent	_____ Date:

Revised: PMS 1/31/13

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EMPLOYMENT VERIFICATION

Note: This form is to be filled out by the employer. Please type or print legibly in black or blue ink.

1. Name: _____ (Last Name) (First Name) (M.I.)	Date of Birth: _____

2. Place of Employment: _____	Tel No: _____
Address:	

3. Position/Title: _____	Date of Hire: _____

4. Employment Status: [ ] Full Time
[ ] Part Time
[ ] Other *(Please specify)*: _____

[ ] Regular [ ] Limited Term [ ] Seasonal [ ] On-Call
[ ] Contractual [ ] Other *(Please specify)*: _____

5. Gross Monthly Income: $ _____

I certify that the information provided above is true and correct.

Certifying Official *(Print Name)*: _____

Signature: _____ Date: _____

Position/Title: _____

Contact Number(s): _____

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FINANCIAL REPORT SHEET

Note: This form is to be filled out by an applicant/petitioner/party. Please type or print legibly in black or blue ink.

I. **INCOME:** Income is a financial return or gain from one's business, labor, or property. It may also be a profit, wage, salary, earning, retirement, payment, etc.

A. **Earned Income** *(examples: Civil Service (Federal) Employment, Government of Guam Employment, Military Earnings, Private Enterprise Income, Self-Employment Income, Property Rental, Commission, Tips, Cash on Hand, etc).*

B. **Unearned Income/Other Sources of Support:** *(examples: Social Security Benefits, Retirement, Child Support, Alimony, Welfare, Food Stamps, WIC, Contribution from Persons, etc).*

List the source(s) of and monthly gross income/support (and co-applicant's if applicable).

Name *(Applicant)*:_____ *(Last Name) (First Name) MI*			Name *(Co-applicant)*:_____ *(Last Name) (First Name) MI*		
	Source(s) of Income	Amount Monthly		Source(s) of Income	Amount Monthly
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		
9			9		
10			10		
11			11		
12			12		
13			13		
14			14		
	Sub Total:			Sub Total:	$
				Total:	**$**

II. **ASSETS:** *List your assets (and co-applicant's if applicable) including the name of financial institution and the current balance. If other, please specify.*

	Type of Asset	Applicant	Co-applicant	Joint	Name of Financial Institution	Current Balance
1	Checking	☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
2	Savings	☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
3	TCD/Money Market	☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
4	Other:	☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
					Total:	**$**

III. **MONTHLY EXPENSES:** *List your monthly expenses (and co-applicant's if applicable).*

A. **CREDITORS:** *Indicate the name of the creditor, remaining balance and monthly payment. If other, please specify.*

		Name of Creditors	Remaining Balance	Monthly Payment
1	Mortgages			
2	Auto Loans			
3	Personal Loans			
4	Credit Cards *ex. Master, Visa, American Express, Department Store Card, Gas Card, etc.*			
5	Other: Life Insurance			
		Total:	**$**	**$**

B. LIVING EXPENSES: *Indicate the monthly expenses and the average monthly payment. If other, please specify.*

	Type of Expense	Average Monthly Payment
1	Rent	
2	Medical Insurances	
3	Dental Insurances	
4	Home Insurances	
5	Auto Insurances	
6	Life Insurances	
7	Power	
8	Water	
9	Gas	
10	Internet/Cable& telephone	
11	Cell phone	
12	Tipping Fee	
13	Tuition/Child Care	
14	Groceries	
15	Other *(Please specify)*	
	Total:	

IV. CERTIFICATION: I / WE CERTIFY THAT THE INFORMATION GIVEN BY ME / US IN THIS FINANCIAL REPORT SHEET IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY / OUR KNOWLEDGE.

_____ _____

Signature *(Applicant)* **Date**

_____ _____

Signature *(Co-applicant)* **Date**