



37 North Maysville Street
Mount Sterling, KY 40353
Phone: (859) 390-3080
gatewaychildrensservices.org

FOSTER PARENT APPLICATION

APPLICANT INFORMATION

Parent Name	
Social Security Number	
Date of Birth	
Home Address	
Email Address	
Phone	Cell: Home:

Parent Name	
Social Security Number	
Date of Birth	
Home Address	
Email Address	
Phone	Cell: Home:

EMPLOYMENT STATUS

Employer Name	
Duration:	
Phone (Work)	

EMPLOYMENT STATUS

Employer Name	
Duration:	
Phone (Work)	

OTHER HOUSEHOLD MEMBERS *(children, family, friends, etc.)*

Name	Date of Birth	Relationship

PAST FOSTER EXPERIENCE: Have you been an approved foster home in the past? YES NO

If Yes, Agency Name _____

Reason for leaving *(if applicable)*: _____

REFERRAL INFORMATION: How did you hear about Gateway Children's Services?

- Event Social Media Flyer Website Signage Foster Parent Friend
 Other _____

FOSTER PLACEMENT INFORMATION

Total Bedrooms in Your Home (<i>including your own</i>)	
Total Bathrooms in Home	
Is there a maximum number of children you would prefer in the home? (<i>e.g. no more than 2 children placed in home</i>)	
Are you open to accepting sibling groups? (<i>2 or more children</i>)	<input type="checkbox"/> YES <input type="checkbox"/> NO
What distance are you willing to travel if needed for the foster child's family visits and appointments? (<i>e.g. 1 hour, no further than Louisville, 100 miles round trip, etc.</i>)	

COMPATIBILITY SURVEY

WE WILL ACCEPT THE FOLLOWING CHILD(REN): *Please select all that apply*

Gender	Age	Special Needs	Child Goal
<input type="checkbox"/> Male	<input type="checkbox"/> 0-3	<input type="checkbox"/> I'd like to learn more	<input type="checkbox"/> Return to Parent
<input type="checkbox"/> Female	<input type="checkbox"/> 4-7	<input type="checkbox"/> Medically Complex (<i>Designated by each child's medical needs - examples could include diabetes, organ transplant recipients, epilepsy, cancer, hypothyroidism, scoliosis, etc.</i>)	<input type="checkbox"/> Long Term Placement
<input type="checkbox"/> Transgender	<input type="checkbox"/> 8-11		<input type="checkbox"/> Adoptive Placement
<input type="checkbox"/> Unknown/other	<input type="checkbox"/> 12-14		<input type="checkbox"/> Respite Only (<i>short term</i>)
	<input type="checkbox"/> 15-17		
	<input type="checkbox"/> 18+	<input type="checkbox"/> Autism/Low IQ	
		<input type="checkbox"/> Sexualized Behaviors	

WE WILL ACCEPT CHILD(REN) WITH THE FOLLOWING:

**Please note our services include working directly with the child(ren) and parent(s) through behaviors.*

- | | |
|--|--|
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Parenting Youth |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Human Trafficking Victim |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Difficulty accepting authority | <input type="checkbox"/> Runaway or AWOL Risk |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Completing Residential Program |
| <input type="checkbox"/> Difficulty with boundaries | <input type="checkbox"/> Property Damage |
| <input type="checkbox"/> Not Potty Trained | <input type="checkbox"/> Physical aggression |
| <input type="checkbox"/> Visits with biological family | <input type="checkbox"/> Animal abuse |
| <input type="checkbox"/> Phone contact with bio family | <input type="checkbox"/> Not able to live with other children |
| <input type="checkbox"/> Different religion than your home | <input type="checkbox"/> Not able to share a room with a child |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Shows no remorse | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Substance Misuse History
(<i>tobacco, drugs, alcohol, etc</i>) | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Fire Setting |
| | <input type="checkbox"/> Other |

SIGNATURE: *I certify that all information provided on this form is correct to the best of my knowledge:*

Parent Signature: _____

Date: _____

Printed name: _____

Parent Signature: _____

Date: _____

Printed name: _____

*Please return this form to 37 North Maysville Street, Mount Sterling, KY 40353
or email me: m.davis@gatewaychildren.org*