



Smiles and Tears Children and Family Services Foster Family Agency



Resource Family Approval Process

We would like to thank you for choosing our agency to make your heart desire become real. Yes, you are just a few steps away of experiencing the most unforgettable and rewardable experience of sharing your home doors open to the less fortunate and indefensible little human beings' targets of abuse and neglect in in our society. You are also, a few steps away to fill up little hearts with lots of love and troubled lives with lots of care, heal wounds and teach happiness. Yes, your actions to help others are priceless. Welcome! You are in the right place, and we look forward to guiding you thru this process. Below you will find the requirements to become approve as Resource (Foster) Parent with Smiles and Tears Children and Family Services, Foster Family Agency.

Step 1: Phone Interview: Basic qualification information obtaining from the applicant and questions from recruiter

Step 2: Orientation: Explain the process and paperwork sections to be read and sign. Once first section is completed, move on to the next section.

Step 3: PRIDE Training: 30 hours of training. Foster Parent College curriculum and in person. Flexible scheduling. Move to next section.

Step 4: Home Study/Home inspection: Assignment of agency social worker to complete the home study report and the final inspection.

Step 5: Certification!: Congratulations you have passed the process and are know a Resource Parent with Smiles and Tears Children and Family Services. The agency will submit your application to the county for clearance and approval.

Please, be aware of the time allowed to complete the approval process of ninety (90) days. After that you may need to re-start all the process again.



Smiles and Tears Children and Family Services Foster Family Agency



Resource Family Requirements

Section-1

- Resource (Foster) Parent Requirements
- Child's Basic Needs
- Resource (Foster) Parents Application
- Live-Scan Form (both)
- Living Arrangements
- Driver's License (both)
- Social Security Card (disclosure)
- Marriage Certificate (if applicable)
- Divorce Decree (if applicable)
- Medical Report/TB test
- CPR/First Aid (infant, Children, Adults)
- DMV Driving Record Report (online report **NOT Accepted**)
- Employment Verification both (if applicable)
- Financial Report
- Home Insurance/Renter's Insurance
- Vehicle Insurance
- Car Inspection
- Rescinded Letter (if applicable)
- Release Authorization Form
- Criminal Record Statement (LIC 508D)
- Report Child Abuse Form
- Pet License/Vaccines/Insurance (if applicable)
- Swimming Pool Photo (if applicable)
- Fire Extinguisher Proof (size 2-A or 3-A)
- Floor and Yard Plan (LIC 999)
- Emergency Plan (LIC610B)

Child's Basic Needs

Room and Board:

Approved resource/foster parents need to provide to each child/youth with a suitable twin-size bed and appropriate clean linen as described in the agency Initial Home Inspection Health and Safety Check List. Basic utilities and daily living utensils. No children will be deprived to enter the house by no means early or late specially if resource parent is dually licensed approved. **NO EXEMPTIONS.**

Food:

Approved resource/foster parent(s) need to provide each youth with healthy food and proper nutrition. The approved parent(s) must provide three nutritionally sound meals each day (breakfast, lunch, and dinner) and have a snack food available. "Junk/fast foods" is discouraged. The approved parent should avoid imposing their personal food preferences on youth. Medical advice needs to be obtained before initiating weight loss programs, and in the instance of any eating disorders or food related problems.

Clothing:

Adequate clothing needs to be provided for the child. This is the financial responsibility of the certified parent. The child should have several sets of clothing for school, for casual activities and at least an outfit suitable for more formal events.

Each child must have appropriate seasonal clothing and an adequate supply of under garments and sleep wear.

Inventories of the child's clothing and personal belongings need to be completed at intake. This form will be kept in the child's file. All clothing receipts should be saved, and purchases recorded in a clothing log.

The Social Worker will oversee these records, observe the child's attire and appearance during weekly visits and see that the certified parents are adhering to the guidelines.

Transportation:

Resource Parents **MUST** be available and provide transportation to all foster children placed for care in your home with no restrictions or limits to the following places as required per the Title 22 and the Interim Licensing Standards (ILS) and the agency agreement, but not limited to the following.

- 1- School of attendance.
- 2- Educational Activities.
- 3- Doctor's appointments, Dental and any other treatment requiring transportation.
- 4- Visits to all authorized by children services or the court.
- 5- Recreational trips etc. Other transportation may be required besides this list, worker will inform you.

Medical Care:

Every foster child is eligible for and entitled to medical care. Every child is covered by Medi-Cal insurance or a private insurance. The County Social Worker (CSW) is responsible for providing foster parents with the child's Medi-Cal card and with new medical eligibility stickers and labels each month. The new Medi-Cal cards are plastic with no labels or stickers. A small number of foster children have private insurance coverage such as Blue Cross or Kaiser.

Characteristics of a Foster Parent

1. **Tolerance for your own feelings:** You accept that you will sometimes like, love or even dislike the child. You understand it is the behavior you do not like, not the child, and the behaviors can be changed.
 2. **Commitment:** You must parent the child not because of reward, gratitude or good feeling. You have made up your mind to do it no matter how it turns out.
 3. **Problem solving skills:** You are able to solve problems in terms of how the whole family functions. This allows for adjusting to needs of each family member and cuts down on fault, blame or scape-goating.
 4. **You refuse to be rejected by the child:** You are usually the one the child chooses to reject, but you refuse to accept the rejection and keep on giving to the child.
 5. **Caringly intrusive:** You continue to be involved in the child's business because you are the parent and this how you "protect and care of the child".
 6. **Solid boundaries:** You convey to the child that, "I care about you, accept you, but I will not let you do whatever." You are a family with a minimum of family rules and the rules exist for the well-being of the family.
 7. **You measure success in progress toward goals rather than in achieving goals:** You are happy with small successes and have long since given up hope that the child will be perfect, and when you gave up your quest for perfection you felt relief not sadness.
 8. **Acceptance of differences:** You think the differences in a child make them special. You are accepting and understanding of the child's history and abilities.
 9. **You consider change:** You realize the child spent years developing these problems and it will take a long time to solve them.
 10. **Communication:** You have positive interaction with your own children, friends, and neighbors and can listen, ask questions, clarify issues, identify feelings and understand double messages. You don't whine, moralize, lecture, ridicule, scold, complain or judge.
 11. **You can share parenting:** You accept the relationship the social worker the placement worker and the birth family has with the child. You can share the child with all the other in their life.
 12. **Your own family needs:** You make time and opportunity for your family to express themselves and have you to themselves.
 13. **You are a loss expert:** You are able to understand the child's feelings of loss and the behaviors that will come from the loss.
 14. **A sense of humor:** You are able to laugh at yourself, your children, the agency, the social worker, the placement workers, and the ludicrous situations you find your self in. If you cannot laugh, the only alternative would be to cry.
- Caring with Love:** Providing care with love it doesn't make feel uncomfortable to others, doesn't incommode, doesn't hurt others, does not point at other faults, please, do your best for the children.

Five Competencies of Fostering

1. Protecting and nurturing the children.
2. Meeting children's developmental needs and addressing their developmental delays.
3. Supporting relationships between children and their families.
4. Connecting children to safe, nurturing relationships intended to last a lifetime.
5. Working as a member of a professional team.

Name/Signature: _____

Date: _____

Name/Signature: _____

Date: _____

Agency Rep. Name/Signature: _____

Date: _____

RESOURCE FAMILY APPLICATION

Agency Use Only
FFA: <u>SMILES AND TEARS CFS</u>

Instructions: This is the application for Resource Family Approval by a foster family agency. Please type or print clearly.

Application **Other (Specify):** _____

I. APPLICANT(S): EACH APPLICANT MUST COMPLETE AN OUT-OF-STATE DISCLOSURE AND CRIMINAL RECORD STATEMENT LIC 508D.

First		Middle	Last	
Applicant One (Legal Name):				
Preferred/Chosen Name:				
Previous Name Used: <i>*including maiden name</i>			Highest Level of Education Completed	
Date of Birth	Gender	Race/Ethnicity	Driver's License Number	
Email Address (Optional)		Cell Phone Number	Home Phone Number	
Name/Address of Employer		Work Phone Number	Occupation	Annual Income

First		Middle	Last	
Applicant Two (Legal Name):				
Preferred/Chosen Name:				
Previous Name Used: <i>*including maiden name</i>			Highest Level of Education Completed	
Date of Birth	Gender	Race/Ethnicity	Driver's License Number	
Email Address (Optional)		Cell Phone Number	Home Phone Number	
Name/Address of Employer		Work Phone Number	Occupation	Annual Income

If more than one applicant, what is your relationship? Please check one.

Married Domestic Partnership Related (Family Member) Cohabitants Other _____

II. APPLICANT(S)' RESIDENCE

Physical Address	City	State	Zip
Mailing Address (If Different)	City	State	Zip
Do you own, rent or lease?	Check one: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Lease		
Weapons in the home?	Check one: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bodies of water?	Check one: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does any person not listed in this document use the residence as their mailing address?	Check one: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who: _____		
Languages spoken in the home:			

III. RELATIONSHIP HISTORY

If currently married or in a domestic partnership with the other applicant:

Date: _____ Place (City and State): _____ N/A

Applicant One:

If currently married or in a domestic partnership with someone who is not an applicant:

Date: _____ Place (City and State): _____ N/A

**Please include the individual in Section V. if the individual resides or is regularly present in the home.*

Have you had previous marital or domestic partnerships?

Yes If yes, how many?: _____ None

Applicant Two:

If currently married or in a domestic partnership with someone who is not an applicant:

Date: _____ Place (City and State): _____ N/A

**Please include the individual in Section V. if the individual resides or is regularly present in the home.*

Have you had previous marital or domestic partnerships?

Yes If yes, how many?: _____ None

IV. MINOR CHILDREN RESIDING IN THE HOME

(PLEASE IDENTIFY DEPENDENT CHILDREN PLACED IN YOUR HOME IN SECTION VI.)

Name of Minor Child	Relationship to Applicant(s)	Date of Birth	Gender	Do You Financially Support This Child?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

V. OTHER ADULTS, INCLUDING ADULT CHILDREN OF APPLICANT(S), RESIDING OR REGULARLY PRESENT IN THE HOME (PLEASE IDENTIFY NMDs PLACED IN YOUR HOME IN SECTION VI.)
EACH ADULT RESIDING OR REGULARLY PRESENT IN THE HOME MUST COMPLETE AN OUT-OF-STATE DISCLOSURE AND CRIMINAL RECORD STATEMENT LIC 508D. (DOES NOT APPLY TO NONMINOR DEPENDENTS)

Full Name (First, Middle Initial & Last)	Date of Birth	Relationship To Applicant(s)	Residing	Regularly Present

VI. CHILD/NMD DESIRED

- Has a child or nonminor dependent been identified? Check one: Yes No
- Is the child or nonminor dependent currently in your home? Check one: Yes No

Name of Child or NMD (First & Last)	Date of Birth	Gender	Relationship to Applicant	Date of Placement or Planned Placement	County of Jurisdiction

VI. CHILD/NMD DESIRED (Continued)

PLEASE INDICATE YOUR PREFERENCES:

Ages(s)				
<input type="checkbox"/> 0 to 2 yrs	<input type="checkbox"/> 3 to 7 yrs	<input type="checkbox"/> 8 to 12 yrs	<input type="checkbox"/> 13 to 15 yrs	<input type="checkbox"/> 16 to 17 yrs
<input type="checkbox"/> 18 to 20 yrs	<input type="checkbox"/> No preference			
Sibling Group				
<input type="checkbox"/> None	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5 or more

VII. FOSTER CARE/ADOPTION/LICENSURE HISTORY

Applicant One:

- Have you previously been or are you currently approved for adoption, an approved relative or nonrelative extended family member, or previously or currently licensed, certified, or approved to provide foster care?

Check one: Yes No

If yes, name of agency(s): _____

Type of license/certification/approval: _____

If yes, are you aware of any pending complaints or administrative actions? Yes No
- Have you previously been or are you currently licensed to operate a child care center, family child care home, or residential care facility for the elderly or chronically ill?

Check one: Yes No

If yes, type of license: _____
- Have you previously been or are you currently employed by or volunteering at a community care facility, child care center, family child care home, or residential care facility for the elderly or chronically ill?

Check one: Yes No

If yes, name the facility(s): _____
- Have you had a previous license, certification, relative or nonrelative extended family member approval, Resource Family approval, or portability application denial?

Check one: Yes No

If yes, name of agency(s): _____
- Have you had a license, certification, or approval suspended, revoked, or rescinded?

Check one: Yes No

If yes, name of agency(s): _____
- Have you been subject to an exclusion order?

Check one: Yes No

VII. FOSTER CARE/ADOPTION/LICENSURE HISTORY (Continued)

Applicant Two:

- Have you previously been or are you currently approved for adoption, an approved relative or nonrelative extended family member, or previously or currently licensed, certified, or approved to provide foster care?
 Check one: Yes No
 If yes, name of agency(s): _____
 Type of license/certification/approval: _____
 If yes, are you aware of any pending complaints or administrative actions? Yes No

- Have you previously been or are you currently licensed to operate a child care center, family child care home, or residential care facility for the elderly or chronically ill?
 Check one: Yes No
 If yes, type of license: _____

- Have you previously been or are you currently employed by or volunteering at a community care facility, child care center, family child care home, or residential care facility for the elderly or chronically ill?
 Check one: Yes No
 If yes, name the facility(s): _____

- Have you had a previous license, certification, relative or nonrelative extended family member approval, Resource Family approval, or portability application denial?
 Check one: Yes No
 If yes, name of agency(s): _____

- Have you had a license, certification, or approval suspended, revoked, or rescinded?
 Check one: Yes No
 If yes, name of agency(s): _____

- Have you been subject to an exclusion order?
 Check one: Yes No

VIII. REFERENCES

Please list the name, telephone number(s), and address of two individuals who have knowledge of your home environment, lifestyle, and ability to be a Resource Family.		
Full Name	Telephone Number(s)	Mailing Address/City/State/Zip or Email Address

IX. APPLICANT(S) DECLARATION

I/We declare that:

- I/We have the financial ability to ensure the stability and financial security of the family.
- In signing this application, I/we understand that the completion of routine forms will or may be required by my/our references, physician, and employer, that my/our financial status will be verified, and a background check will be conducted.
- I/We affirm that the information provided on this form is true, correct, and contains no material omissions of fact to the best of my/our knowledge and belief.
- I/We understand any false or misleading statements willfully or knowingly made to the foster family agency or Department, or failure to disclose material facts to obtain or maintain Resource Family approval can result in a denial or rescission of a Resource Family approval.
- I/We understand that personal information contained on this application may be shared with the following:
 - (1) A placement agency or juvenile court for the purpose of determining whether to place a child or nonminor dependent.
 - (2) Any approval agency to which a Resource Family applies for subsequent approval.
 - (3) A tribal agency.
 - (4) The State Department of Social Services.
 - (5) A member of a child welfare agency in the sending state for placement pursuant to the Interstate Compact on the Placement of Children.
 - (6) As otherwise required by law.

Applicant(s) Signature	City & County Where Signed	Date
Applicant One:		
Applicant Two:		

Resubmission of Application		
If this application is being resubmitted within 12 months of a withdrawal, the foster family agency shall verify the information is current and require the applicant(s) to sign below.		
Applicant(s) Signature	City & County Where Signed	Date
Applicant One:		
Applicant Two:		
FFA SW Personnel:		

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
PERSONAL REFERENCE

For Office use only
Personal reference verification
Verified by: _____ Date: _____

Applicant (s) Name (s): _____

The applicant (s) mentioned above have applied to become certified as Resource Parent (s) with **Smiles and Tears Foster Family Agency**. We are asking if you can provide us with your truthful answers on this recommendation letter. Your answers are confidential and will help us in making a wise evaluation of the applicant (s) application. Please complete this form and mail it back to our agency at the following address:

SMILES AND TEARS CHILDREN AND FAMILY SERVICES FFA
925 NORTH GAREY AVENUE, POMONA, CA 91767
We thank you in advance for your cooperation.

1. How long have you known this applicant (s)? Years _____ Months _____
Please describe the level of friendship you have with this family. (close, casual etc..) _____

2. Have you ever observed how this parent (s) cares for their children? Yes _____ No _____
If your answer is "YES" please explain: _____

3. Do you know if they have any experience with children that have or may have had medical problems or emotional issues: Yes _____ No _____ If your answer is "YES" please explain: _____

4. If you had to leave your child/children under the care of the applicant (s) would you leave them under Their care? Yes _____ No _____ If your answer is "YES" please explained: _____

5. Please describe in your own words your thoughts of the applicant (s) home: (cleanliness, enough space, outdoor space etc..) _____

6. Use this space for any additional information you may have to help us fully evaluate this applicant (s): _____

Print/Signature: _____ Phone: _____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Relationship: _____

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
PERSONAL REFERENCE

For Office use only
Personal reference verification
Verified by: _____ Date: _____

Applicant (s) Name (s): _____

The applicant (s) mentioned above have applied to become certified as Resource Parent (s) with **Smiles and Tears Foster Family Agency**. We are asking if you can provide us with your truthful answers on this recommendation letter. Your answers are confidential and will help us in making a wise evaluation of the applicant (s) application. Please complete this form and mail it back to our agency at the following address:

SMILES AND TEARS CHILDREN AND FAMILY SERVICES FFA
925 NORTH GAREY AVENUE, POMONA, CA 91767
We thank you in advance for your cooperation.

1. How long have you known this applicant (s)? Years _____ Months _____
Please describe the level of friendship you have with this family. (close, casual etc..) _____

2. Have you ever observed how this parent (s) cares for their children? Yes _____ No _____
If your answer is "YES" please explain: _____

3. Do you know if they have any experience with children that have or may have had medical problems or emotional issues: Yes _____ No _____ If your answer is "YES" please explain: _____

4. If you had to leave your child/children under the care of the applicant (s) would you leave them under Their care? Yes _____ No _____ If your answer is "YES" please explained: _____

5. Please describe in your own words your thoughts of the applicant (s) home: (cleanliness, enough space, outdoor space etc..) _____

6. Use this space for any additional information you may have to help us fully evaluate this applicant (s): _____

Print/Signature: _____ Phone: _____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Relationship: _____



REQUEST FOR LIVE SCAN SERVICE

1 **licant Submission**

AL093 RESOURCE FAMILY PER 16519.5 W
ORI (Code assigned by DOJ) Authorized Applicant Type

RESOURCE FAMILY HOME
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

SMILES AND TEARS CHILDREN AND FAMILY SERVICES 21598
Agency Authorized to Receive Criminal Record Information Mail Code (five-digit code assigned by DOJ)

POST OFFICE BOX 2741 JOSE FRANCISCO ISLAS
Street Address or P.O. Box Contact Name (mandatory for all school submissions)

POMONA CA 91769 9094699580
City State ZIP Code Contact Telephone Number

Applicant Information:

Last Name First Name Middle Initial Suffix

Other Name: (AKA or Alias)

Last Name First Name Suffix

Sex Male Female

Date of Birth Driver's License Number

Height Weight Eye Color Hair Color
Billing Number

Place of Birth (State or Country) Social Security Number
Misc. Number

Home Address City State ZIP Code
Street Address or P.O. Box

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number: 197806568
OCA Number (Agency Identifying Number)

Level of Service: DOJ FBI CACI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number: _____
(Must provide proof of rejection) Original ATI Number

Employer (Additional response for agencies specified by statute):

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
Employer Name

POST OFFICE BOX 2741 9094699580
Street Address or P.O. Box Telephone Number (optional)

POMONA CA 91769 21598
City State ZIP Code Mail Code (five digit code assigned by DOJ)

L **Scan Transaction Completed By:**

Name of Operator Date

Transmitting Agency LSID ATI Number Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Business and Professions Code sections 4600-4621, 7574-7574.16, 26050-26059, 11340-11346, and 22440-22449; Penal Code sections 11100-11112, and 11077.1; Health and Safety Code sections 1522, 1416.20-1416.50, 1569.10-1569.24, 1596.80-1596.879, 1725-1742, and 18050-18055; Family Code sections 8700-87200, 8800-8823, and 8900-8925; Financial Code sections 1300-1301, 22100-22112, 17200-17215, and 28122-28124; Education Code sections 44330-44355; Welfare and Institutions Code sections 9710-9719.5, 14043-14045, 4684-4689.8, and 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at <http://oag.ca.gov/privacy-policy>.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to process applications pertaining to Live Scan service to help determine the suitability of a person applying for a license, employment, or a volunteer position working with children, the elderly, or the disabled, we may need to share the information you give us with authorized applicant agencies.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes.
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice or access to your records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at keeperofrecords@doj.ca.gov, or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis
Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170



REQUEST FOR LIVE SCAN SERVICE

Privacy Act Statement

Authority. The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose. Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses. During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental, or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.



REQUEST FOR LIVE SCAN SERVICE

licant Submission

AL093 RESOURCE FAMILY PER 16519.5 W
ORI (Code assigned by DOJ) Authorized Applicant Type

RESOURCE FAMILY HOME
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

SMILES AND TEARS CHILDREN AND FAMILY SERVICES 21598
Agency Authorized to Receive Criminal Record Information Mail Code (five-digit code assigned by DOJ)

POST OFFICE BOX 2741 JOSE FRANCISCO ISLAS
Street Address or P.O. Box Contact Name (mandatory for all school submissions)

POMONA CA 91769 9094699580
City State ZIP Code Contact Telephone Number

Applicant Information:

Last Name First Name Middle Initial Suffix

Other Name: (AKA or Alias)
Last Name First Name Suffix

Date of Birth Sex Male Female Driver's License Number

Height Weight Eye Color Hair Color Billing Number

Place of Birth (State or Country) Social Security Number Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box City State ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number: 197806568
OCA Number (Agency Identifying Number)

Level of Service: DOJ FBI CACTI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number: _____
(Must provide proof of rejection) Original ATI Number

Employer (Additional response for agencies specified by statute):

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
Employer Name

POST OFFICE BOX 2741 9094699580
Street Address or P.O. Box Telephone Number (optional)

POMONA CA 91769 21598
City State ZIP Code Mail Code (five digit code assigned by DOJ)

Scan Transaction Completed By:

Name of Operator Date

Transmitting Agency LSID ATI Number Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Business and Professions Code sections 4600-4621, 7574-7574.16, 26050-26059, 11340-11346, and 22440-22449; Penal Code sections 11100-11112, and 11077.1; Health and Safety Code sections 1522, 1416.20-1416.50, 1569.10-1569.24, 1596.80-1596.879, 1725-1742, and 18050-18055; Family Code sections 8700-87200, 8800-8823, and 8900-8925; Financial Code sections 1300-1301, 22100-22112, 17200-17215, and 28122-28124; Education Code sections 44330-44355; Welfare and Institutions Code sections 9710-9719.5, 14043-14045, 4684-4689.8, and 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at <http://oag.ca.gov/privacy-policy>.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to process applications pertaining to Live Scan service to help determine the suitability of a person applying for a license, employment, or a volunteer position working with children, the elderly, or the disabled, we may need to share the information you give us with authorized applicant agencies.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes.
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice or access to your records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at keeperofrecords@doj.ca.gov, or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis
Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170



REQUEST FOR LIVE SCAN SERVICE

Privacy Act Statement

Authority. The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose. Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses. During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental, or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

SMILES AND TEARS CHILDREN AND FAMILY SERVICES

Living Arrangements Information Plan

INSIDE OF HOUSE:

1. Please provide the information requested below for each bedroom in your home:

	Bedroom Size	No. of Windows	No. of Beds	Occupants of Bedroom (Age and Sex)
Room 1				
Room 2				
Room 3				
Room 4				
Room 5				
Room 6				

- This is a:
- | | | |
|----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> 1 story | <input type="checkbox"/> 2 story | <input type="checkbox"/> 3 story |
| <input type="checkbox"/> House | <input type="checkbox"/> Apartment | <input type="checkbox"/> Mobile Home |
- Fenced Yard? [] Yes [] No
 Swimming Pool? [] Yes [] No

OUTSIDE OF HOUSE:

1. Completely Fenced: [] Yes [] No Height of Fence: _____
2. Water Supply: [] Well [] Public No. of ponds on property: _____
3. Are bodies of water separately fenced from play area? [] Yes [] No
4. Livestock or pets? (number and kind): _____
5. Name of nearest elementary school: _____
6. Name of nearest middle/Jr. high school: _____
7. Name of nearest senior high school: _____

APPLICANT SIGNATURES VERIFYING THAT INFORMATION PROVIDED HEREIN IS ACCURATE:

Applicant Signature #1	Date	Applicant Signature #2	Date
------------------------	------	------------------------	------

STCFS Representative Signature: _____ Date: _____

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME	SMILES AND TEARS FOSTER FAMILY AGENCY
FACILITY ADDRESS	

PERSON'S NAME	AGE
POSITION TITLE	TYPE OF FACILITY
	WORK DAYS PER WEEK
	WORK HOURS PER DAY
DUTY STATEMENT	

TYPES OF PERSONS SERVED (Check appropriate items)

- | | | | |
|--|----------------------------------|---|---|
| <input checked="" type="checkbox"/> Infants | <input type="checkbox"/> Adults | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Physically Handicapped |
| <input checked="" type="checkbox"/> Children | <input type="checkbox"/> Elderly | <input type="checkbox"/> Mentally Disordered | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> Other (specify) | | | |

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
---	---------	------

NOTE TO PHYSICIAN: Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	<input type="checkbox"/> POSITIVE	ACTION TAKEN (IF POSITIVE)
	<input type="checkbox"/> NEGATIVE	
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)	DATE
HEALTH SCREENING BY: (ORIGINAL SIGNATURE)	TELEPHONE #	DATE



EMPLOYER PULL NOTICE PROGRAM
AUTHORIZATION FOR
RELEASE OF DRIVER RECORD INFORMATION

I, _____, California Driver License Number, _____
hereby authorize the California Department of Motor Vehicles (DMV) to disclose or otherwise make available, my driving record,
to my employer, _____

COMPANY NAME

I understand that my employer may enroll me in the Employer Pull Notice (EPN) program to receive a driver record report at least once every twelve (12) months or when any subsequent conviction, failure to appear, accident, driver's license suspension, revocation, or any other action is taken against my driving privilege during my employment.

I am not driving in a capacity that requires mandatory enrollment in the EPN program pursuant to California Vehicle Code (CVC) Section 1808.1(k). I understand that enrollment in the EPN program is in an effort to promote driver safety, and that my driver license report will be released to my employer to determine my eligibility as a licensed driver for my employment.

EXECUTED AT: CITY

COUNTY

STATE

DATE

SIGNATURE OF EMPLOYEE

X

I, _____, of _____
AUTHORIZED REPRESENTATIVE COMPANY NAME

do hereby certify under penalty of perjury under the laws in the State of California, that I am an authorized representative of this company, that the information entered on this document is true and correct, to the best of my knowledge and that I am requesting driver record information on the above individual to verify the information as provided by said individual. This record is to be used by this employer in the normal course of business and as a legitimate business need to verify information relating to a driving position not mandated pursuant to CVC Section 1808.1. The information received will not be used for any unlawful purpose. I understand that if I have provided false information, I may be subject to prosecution for perjury (Penal Code Section 118) and false representation (CVC Section 1808.45). These are punishable by a fine not exceeding five thousand dollars (\$5,000) or by imprisonment in the county jail not exceeding one year, or both fine and imprisonment. I understand and acknowledge that any failure to maintain confidentiality is both civilly and criminally punishable pursuant to CVC Sections 1808.45 and 1808.46.

EXECUTED AT: CITY

COUNTY

STATE

DATE

SIGNATURE AND TITLE OF AUTHORIZED REPRESENTATIVE

X

To obtain a driver record on a prospective employee you may submit an INF 1119 form. To add this driver to the EPN Program you must submit the applicable forms: INF 1100, INF 1102, INF 1103, INF 1103A form. You may obtain forms at our website at www.dmv.ca.gov/otherservices, or by calling 916-657-6346.

THIS FORM MUST BE COMPLETED AND RETAINED AT THE EMPLOYER'S PRINCIPAL PLACE OF BUSINESS AND MADE AVAILABLE UPON REQUEST TO DMV STAFF.

DO NOT RETURN THIS FORM TO DMV.

SMILES AND TEARS CHILDREN AND FAMILY SERVICES

EMPLOYMENT VERIFICATION

TO: (Company Name): _____
 address: _____ City: _____ Zip-code: _____
 Contact name: _____ Phone #: _____ Fax #: _____ E-mail: _____

This agency is considering the person named below as a potential Foster/Adoptive Parent. We would appreciate it if you would complete this form and provide us with information related to his or her reliability, ability to respect rules and authority, and work performance and attendance and basic income. **Please return the completed form** in the enclosed self-addressed envelope. Thank you

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to provide any and all information requested regarding my employment.

 Employee's print name & signature

 Date

Employee: First Name: _____ Last Name: _____ SSN#: _____
 Street Address: _____ City: _____ State: _____ Zip: _____

Employee's Position/Title: _____

Date Hired: Month _____ Day _____ Year _____

Type of employment: Full Time Part Time Seasonal Basis

Continuous Services? Yes No

Salary: \$ _____ Per _____ Month Season Year

Possibility of advancement: _____

Attitude toward work: _____

Ability to get along with others: _____

If employment has terminated, please complete the following:

Reason for termination: _____

Reemployment possibilities: _____

Remarks: _____

 Printed Name of Authorized Representative

 Signature of Authorized Representative

 Date

**SMILES AND TEARS CHILDREN AND FAMILY SERVICES
FINANCIAL STATEMENT/ MONTHLY BUDGET**

Net Monthly Income (Take-Home) & Stipend	
Source	Amount (monthly)
1.	\$
2.	\$
3.	\$
4.	\$
Total Monthly Income:	\$
Total Foster Care and/or Adoption Assistance Stipend:	\$

Vehicles (Automobiles, etc.)			
Make/Model	Year	Monthly Payment	Balance Due
		\$	\$
		\$	\$
		\$	\$
Total:		\$	\$

Household Expenses		
Category	Monthly Expense	Balance Due
Total Vehicle Payments (from above)	\$	\$
<input type="radio"/> Mortgage <input type="radio"/> Rent (select one) (Include insurance and taxes)	\$	\$
Utilities	\$	\$
Food/Groceries	\$	\$
Transportation (gas, insurance, etc.)	\$	\$
Credit Card Debt	\$	\$
Other Loans	\$	\$
Child Care	\$	\$
Education (tuition)	\$	\$
Medical Expense & Medical Insurance	\$	\$
Clothing	\$	\$
Entertainment	\$	\$
Charitable Contributions	\$	\$
Miscellaneous (specify):	\$	\$
	\$	\$
	\$	\$
Total:	\$	\$

Name of Bank(s): _____
 Checking Balance: \$ _____ as of ___/___/___; Savings Balance: \$ _____ as of ___/___/___
 Gross taxable income claimed on last tax return: \$ _____ Tax Year _____

I verify that the above information is complete and accurate:

Applicant Name: _____ Signature: _____ Date: _____

Co-Applicant Name: _____ Signature: _____ Date: _____

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
VEHICLE INSPECTION CHECK

Initial Annual Other, please specify: _____

Applicant Name: _____

Date: _____

Vehicle Make: _____

Year: _____

License Plate #: _____

Mileage: _____

	Good	Poor	If Repairs Needed, Please Specify
Windshield Wipers	_____	_____	_____
Windows	_____	_____	_____
Mirrors	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	_____
Headlights	_____	_____	_____
Taillights	_____	_____	_____
Emergency Flashers	_____	_____	_____
Turn Indicators			
Front Right/Left	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	_____
Rear Right/Left	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	_____
Brakes			
Rear Lights	_____	_____	_____
Tire Condition			
Front Right/Left	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	_____
Rear Right/Left	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	<u>R</u> <input type="checkbox"/> <u>L</u> <input type="checkbox"/>	_____
Steering / Alignment	_____	_____	_____
Seat Belts	_____	_____	_____
Infant Car Seat/Booster Seat	_____	_____	_____
Cell phone hands free bluetooth	_____	_____	_____
Other	_____	_____	_____

Vehicles transporting foster children must be maintained in safe operating conditions, must be insured and a vehicle safety check obtained yearly. Vehicle must always be available (24 hours) with space always available for foster children. Children must be secured in a car seat or harness; children 6 years and under 60lbs must be placed in a car seat. The use of booster seats is required for toddlers over 60lbs and older than 6 years old as required by law.

All drivers transporting foster children must have a car insurance (we must copy on file) current California driver's license must be at least 18 years old, DMV print out, and must be approved by the agency. Resource Parents must always make prudent decisions regarding vehicles being used to transport minors and should always use safety precautions.

An inspection was made on this date, the results of the inspection and recommendations are listed above accordingly.

Agency Name: Smiles and Tears C.F.S FFA

Address: 925 N Garey Ave, Pomona CA 91767

Inspector's Signature/Print: _____ Date: _____

Resource Parent/Applicant Signature: _____ Date: _____

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

(AGENCY OR INDIVIDUAL FROM WHOM INFORMATION IS REQUESTED)

To:

I, _____, RESIDING AT _____

_____, HEREBY AUTHORIZE YOU TO RELEASE TO THE

(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER) _____ SPECIFIC

INFORMATION REQUESTED BY THIS AGENCY WHICH I CANNOT PROVIDE CONCERNING _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE _____

THIS FORM WAS COMPLETED IN ITS ENTIRETY AND WAS READ BY ME (OR READ TO ME) PRIOR TO SIGNING.

SIGNATURE OF APPLICANT

DATE

BIRTHPLACE

BIRTHDATE

MAIDEN NAME OF MOTHER

SIGNATURE OR NAME OF SPOUSE

DATE

BIRTHPLACE OF SPOUSE

BIRTHDATE OF SPOUSE

MAIDEN NAME OF SPOUSE'S MOTHER

OUT-OF-STATE DISCLOSURE & CRIMINAL RECORD STATEMENT

Foster Family Homes, Small Family Homes, Certified Family Homes, Resource Families

*Complete both pages and sign on page 2.***I. OUT-OF-STATE DISCLOSURE**

Foster Family Homes, Small Family Homes, Certified Family Homes, and Resource Families at time of application only

Have you lived in a state other than California within the last five years? YES NO

If YES, identify each state and complete an LIC 198B for each state listed:

II. CRIMINAL RECORD STATEMENT

Foster Family Homes, Small Family Homes, Certified Family Homes, Resource Families

*State law requires that a person associated with licensed facilities or approved homes be fingerprinted, and disclose any conviction. A conviction means a plea or verdict of guilty or a conviction following a plea of nolo contendere (no contest). The fingerprints will be used to obtain a copy of any criminal history you have.*Have you ever been convicted of a crime in California? YES NO*You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7 or a conviction for which relief has been granted pursuant to Penal Code section 1203.49.*Have you ever been convicted of a crime in another state, federal court, military, or a jurisdiction outside of the U.S.? YES NO

For Foster Family and Certified Family Homes & Resource Families only

Have you ever been arrested for a crime against a child or for spousal/cohabitant abuse? YES NOCriminal convictions from another State or Federal court are considered the same as criminal convictions in California

If YES, give details on the back of this page indicating the nature and circumstances of each crime, date and location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

- It happened a long time ago;
- It was only a misdemeanor;
- You didn't have to go to court (your attorney went for you);
- You had no jail time or the sentence was only a fine or probation;
- You received a certificate of rehabilitation; or
- The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) MAY RESULT IN AN EXEMPTION DENIAL, APPLICATION DENIAL, LICENSE REVOCATION, DECERTIFICATION, RESCISSION OF APPROVAL, OR EXCLUSION FROM A LICENSED FACILITY, CERTIFIED FAMILY HOME, OR THE HOME OF A RESOURCE FAMILY.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.		
LICENSED FACILITY, CERTIFIED FAMILY HOME, OR RESOURCE FAMILY NAME: Smiles and Tears Children and Family Services		FACILITY NUMBER: 197806568
YOUR NAME (Print clearly):		
YOUR ADDRESS (street, city, state, zip):		
SOCIAL SECURITY NUMBER: (SEE PRIVACY STATEMENT ON REVERSE)	DRIVER'S LICENSE NUMBER/STATE:	DATE OF BIRTH:
SIGNATURE:		DATE:

INSTRUCTIONS:

If you have been convicted of a crime in California, another state, federal court, military court, or jurisdiction outside the United States, then provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7 or a conviction for which relief has been granted pursuant to Penal Code section 1203.49.)

What was the offense? _____

In which state and city did you commit the offense? _____

When did this happen? _____

Tell us what happened. (Use additional paper if needed) _____

I declare under penalty of perjury under the laws of the State of California that the above information is true and correct to the best of my knowledge.

Signature: _____ **Date:** _____

If you have any questions about this form, please contact your local licensing regional office or approval agency.

INSTRUCTIONS TO LICENSEES ONLY:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility personnel file and send a copy to your LPA.

INSTRUCTIONS TO REGIONAL OFFICES AND FOSTER FAMILY AGENCIES:

If the person discloses that they have lived in another state within the last five (5) years, send this form and LIC 198B to the Caregiver Background Check Bureau, 744 P Street, MS T9-15-62, Sacramento, CA 95814.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be approved, licensed, work at, or be present at, a licensed facility, a certified family home, or home of a resource family, the law requires that you complete a criminal background check. (Health and Safety Code sections 1517, 1522, 1568.09, 1569.17 and 1596.871; Welfare and Institutions Code section 16519.5) The licensing or approval agency will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the licensing or approval agency (Civil Code section 1798 et seq.). Under the California Public Records Act, the licensing or approval agency may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

SMILES AND TEARS CHILDREN AND FAMILY SERVICES

STATEMENT ACKNOWLEDGING REQUIREMENTS TO REPORT CHILD ABUSE

California law **REQUIRES** certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a childcare institution, **YOU** are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a childcare institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows, or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated

agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a misdemeanor punishable by up to six months in jail, a fine of \$1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or childcare institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBILITY

I, _____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

Resource Parent name & Signature: _____

Date: _____

Resource Parent name & Signature: _____

Date: _____

Agency Representative name & Signature: _____

Date: _____

SMILES AND TEARS CHILDREN AND FAMILY SERVICES

STATEMENT ACKNOWLEDGING REQUIREMENTS TO REPORT CHILD ABUSE

California law **REQUIRES** certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a childcare institution, **YOU** are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a childcare institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows, or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated

agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of \$1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or childcare institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBILITY

I, _____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

Resource Parent name & Signature: _____ Date: _____

Resource Parent name & Signature: _____ Date: _____

Agency Representative name & Signature: _____ Date: _____

**SMILES AND TEARS CHILDREN AND FAMILY SERVICES
SWIMMING POOL/SPA AGREEMENT**

These requirements apply to homeowner's and renters (home or apartment)

- My home **Does Not** have a body of water of any type.
- My home **Does** have a body of water that does not require a rescuer's ability to swim.

ABOVE-GROUND POOLS* MUST:

**Requires Water Safety Certificate*

- Have sides that are at least 5' (five feet) high.
- Have removable stairs or ladder that can be stored out-of-reach of children when not in use.
- My home has an out-of-ground pool that **Does** meet State Licensing requirements.
- My home has an out-of-ground pool that **Does Not** meet State Licensing requirements, so I agree to drain my pool until it can be brought up on the above listed safety codes.

IN-GROUND POOL* (AND PONDS) FENCING MUST:

** Requires Water Safety Certificate*

- Be at least 5' (five feet) high around the perimeter of the pool.
- Provide an unobstructed view of the pool.
- Have a gate that opens away from the pool.
- Have a self-closing, self-latching gate with the latch at the top.
- Have a latch that can be locked when not in use.

Acceptable Fencing Material:

- Rod-iron with no more than 4'' spaces between bars
- Wire, that cannot be easily broken, with no more than 1 ¾ openings
- Licensed approved mesh

POOL AND SPA COVERS MUST:

- Be capable of supporting the weight of an adult. (You will be asked to stand on it)
- Be closed and locked at all times when the pool is not in use.
- If automated, have the operating mechanism out-of-reach of children or locked at all times.
- If manual, be locked when not in use.
- My home has a body of water that **Does** meet State Licensing requirements.
- My home has a body of water (other than a built-in-pool) that **Does Not** meet State Licensing requirements, and so I agree to drain the water feature until it can be brought up to the above listed safety codes.
- My home as a wading pool. I agree to empty the wading pool and turn it upside-down when not in use. I will never allow a foster child to fill or use the pool without adult supervision.

I certify the above information is true and correct to the best of my knowledge. I will immediately notify STCFS if I add a pool, spa or water feature of any type to my home, or if I change any existing pool, spa or other water feature. I will also report changes to any fence or cover.

A HOME WHERE AN IN-GROUND POOL OR WATER FEATURE (I.E. POND, LARGE FOUNTAIN, STREAM, ETC) DOES NOT MEET LICENSING REQUIREMENTS CANNOT BE APPROVED.

Applicant Signature

Date

Applicant Signature

Date

STCFS Representative

Date

SMILES AND TEARS CHILDREN AND FAMILY SERVICES, FFA
FIRE EXTINGUISHER POLICY AGREEMENT

This policy agreement is made between me (foster parent) and Smiles and Tears Children and Family Services to maintain and have mounted appropriately a 2A 10 ABC fire extinguisher fully charged at all times. I understand that if I need two or more I will keep it in the same conditions as required by the agency and Title 22 regulations.

Fire Extinguisher Type: _____

Date Purchased: _____

Expiration Date: _____

Initials: _____

***Please attach receipts of new fire extinguisher or recharged fire extinguisher.**

NOTE: Failure to comply with this policy will result in hold status until deficiency is corrected.

Applicant #1 Signature Date

Applicant #2 Signature Date

STCFS Representative Date

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
EMERGENCY CARE/DISASTER ACTION PLAN

Name: _____

Phone: _____

Address: _____

Emergency Phone: _____

Draw a detailed floor plan of your home showing: 1. the dimensions of each room, 2. where the exit locations are, 3. emergency meeting location. Use the following symbols: E Electricity shut-off, S Smoke detectors, W Windows, FE Fire extinguisher, ≠ Water shut-off, --- Fences, F 1st Aid Kit, G Gas shut-off

PLEASE LIST THE PHONE NUMBERS FOR THE FOLLOWING:

Emergency: _____ Fire: _____ Police: _____

Poison Control: _____ Ambulance: _____ Hospital: _____

Doctor: _____ Dentist: _____ Red Cross: _____

Electric Co: _____ Gas Co: _____ Water Co: _____

Crisis Ctr: _____ Child Abuse Hotline: _____

CA Missing Children: 1-800-222-3463

SMILES AND TEARS CHILDREN AND FAMILY SERVICES, INC

PHYSICAL PLAN INFORMATION

INSIDE THE HOUSE:

Room #	Bedroom Size	# of Windows	# of Beds	Occupants of Bedroom (Age & Sex)
Room #1				
Room #2				
Room #3				
Room #4				
Room #5				
Room #6				

This is as: 1 Story Floor 2-Story Floor 3 Story Floor
 House Apartment Mobile Home

Fenced Yard? Yes No
 Swimming Pool? Yes No

OUTSIDE THE HOUSE:

1. Completely Fenced: Yes No Height of Fence: _____
2. Water Supply: Well Public # of ponds on property: _____
3. Are bodies of water separately fenced from play area? Yes No
4. Livestock or pets? (Number and kind): _____
5. Name of nearest elementary school: _____
6. Name of nearest middle/Jr. high school: _____
7. Name of nearest senior high school: _____

APPLICANT SIGNATURES VERIFY THAT INFORMATION PROVIDED HEREIN IS ACCURATE:

 Applicant #1 Signature Date

 Applicant #2 Signature Date

 STCFS Representative Date

SMILES AND TEARS CHILDREN AND FAMILY SERVICES
FIRE SAFETY PLAN

Exit Plan: _____

Supervision and identification of children after evacuation or relocation: _____

Telephone number in case of fire: _____

Instructions to your child (ren): _____

Applicant Signature Date

Applicant Signature Date

**SMILES AND TEARS CHILDREN AND FAMILY SERVICES, FFA
FIRE EXTINGUISHER POLICY AGREEMENT**

This policy agreement is made between me (foster parent) and Smiles and Tears Children and Family Services to maintain and have mounted appropriately a 2A 10 ABC fire extinguisher fully charged at all times. I understand that if I need two or more I will keep it in the same conditions as required by the agency and Title 22 regulations.

Fire Extinguisher Type: _____ Date Purchased: _____

Expiration Date: _____ Initials: _____

***Please attach receipts of new fire extinguisher or recharged fire extinguisher.**

NOTE: Failure to comply with this policy will result in hold status until deficiency is corrected.

Applicant #1 Signature Date

Applicant #2 Signature Date

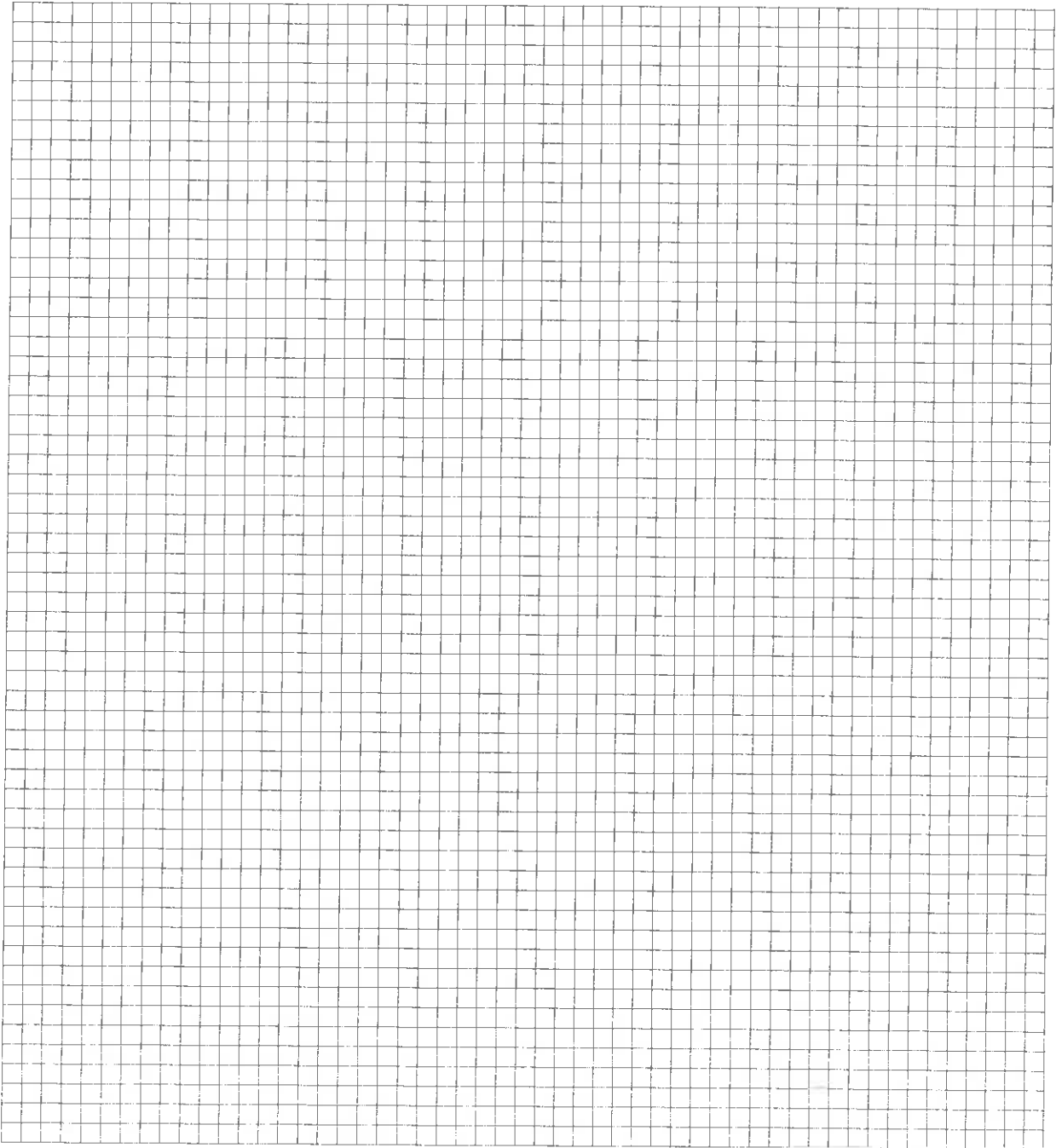
STCFS Representative Date

FACILITY SKETCH (Floor Plan)

Applicants are required to provide a sketch of the floor plan of the home or facility and outside yard. The floor sketch must label rooms such as the kitchen, bath, living room, etc. Circle the names of the rooms that will be used by staff/residents/clients/children. Door and window exits from the rooms must be shown in case of an emergency (see Emergency Disaster Plan). Show room sizes (e.g. 8.5 x 12). Keep close to scale. Use the space below. See back for yard sketch.

FACILITY NAME:

ADDRESS:

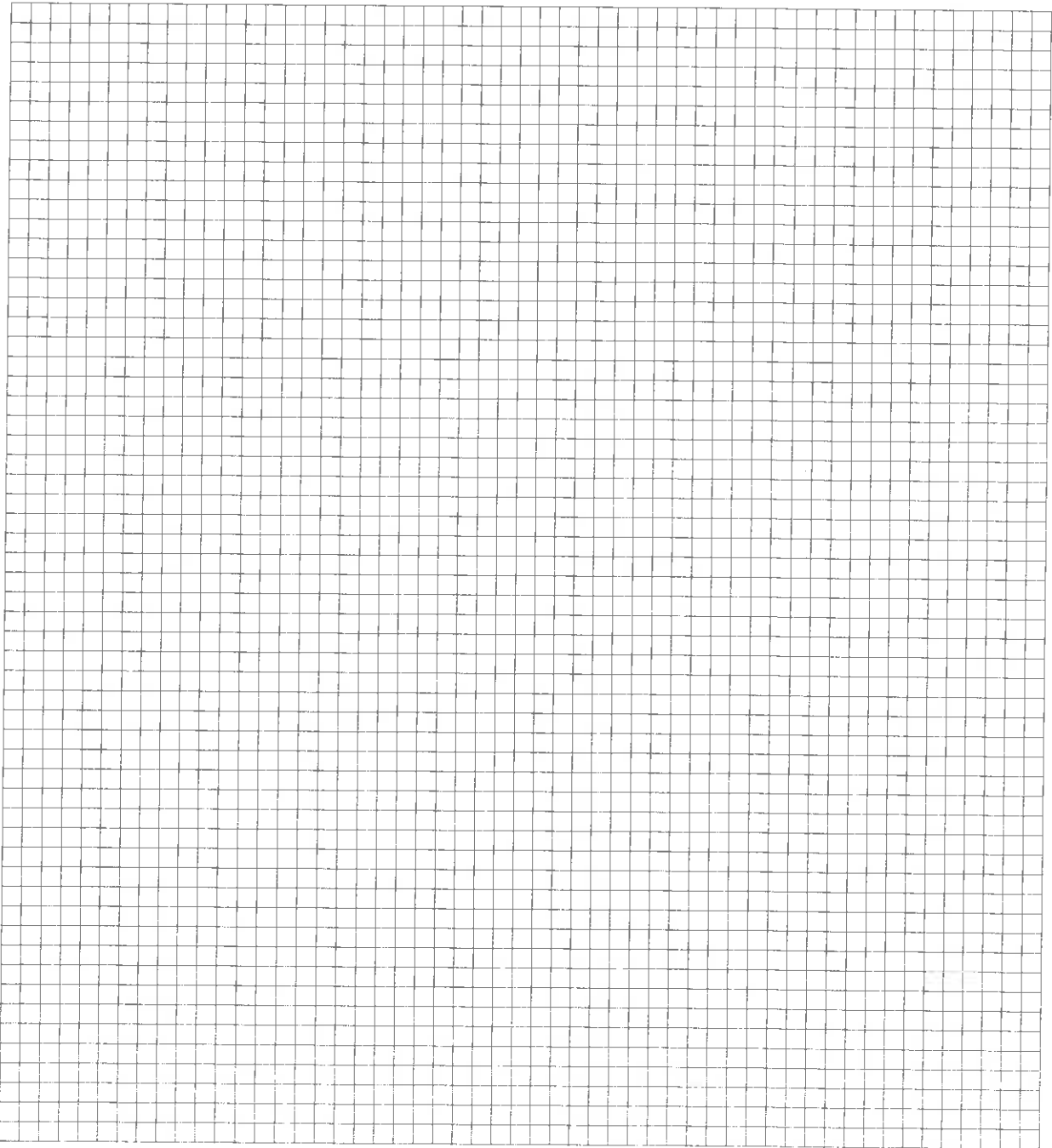


FACILITY SKETCH (Yard)

The yard sketch should show all buildings in the yard including the home (with no detail), garage and storage building. Include walks, driveways, play area, fences, gates. Show any potential hazardous area such as pools, garbage storage, animal pens, etc. Show the overall yard size. Try to keep the sizes close to scale. Use the space below.

FACILITY NAME:

ADDRESS:



EMERGENCY PLAN FOR FOSTER FAMILY HOMES

Type or print clearly. Post emergency numbers where readily available

CAREGIVER NAME:	DATE:
-----------------	-------

1. EMERGENCIES - LIFE THREATENING - Call 9-1-1 - Tell them: Number Calling from:

HOME ADDRESS:

MAJOR CROSSROAD:

HOME DIRECTION FROM CROSSROAD:

2. EMERGENCIES - NON-LIFE THREATENING - List direct local number for the following.

Fire/Paramedics:	Child Protective Services:	Foster Care Ombudsman Office:	
Physician:	Licensing:	Crisis Center:	Other:
Hospital:	Police/Sheriff:		
Dentist:	Poison Control:		

3. OTHER EMERGENCY CONTACTS: - List numbers that may be helpful after a disaster or emergency.

SOCIAL WORKER:	OTHER:
PROBATION OFFICER:	
SUBSTITUTE CAREGIVER:	

4. HOME EVACUATION - Some emergencies require evacuation of the home. Review the safest way to exit rooms. Be sure that exit doors are not locked from the inside. In the event of an emergency, get everyone out, follow the escape routes, meet at a prearranged location and account for everyone. Do not let anyone return to the home until it is safe.**5. UTILITY SHUT OFF - Know where your utilities are located.**

GAS:	GAS CO. PHONE:
ELECTRIC:	ELECTRIC CO. PHONE:
WATER:	WATER CO. PHONE:

6. EQUIPMENT LOCATION - The fire department may help you with installation information.

FIRE EXTINGUISHER: (IF REQUIRED)	SMOKE ALARM:
FIRE ALARM LOCATION (IF YOU HAVE ONE):	TYPE

7. OTHER EMERGENCY EQUIPMENT - Location of first aid kit, blankets, food and water, flashlight, radio and other emergency equipment.

LOCATION:
