



## COLORADO DEPARTMENT OF HUMAN SERVICES

### Original Application to Care for Children and Youth

\* Denotes sections required for non-certified kinship care applicants to complete

<b>Date of Application*:</b>					
<b>Area of Interest*:</b> (mark all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Foster Care Home	Respite	Kinship Foster Care Home	Adoption	Non-Certified Kinship Care
<b>Are you interested in a specific child or youth*?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, what is the name of the child or youth and your relationship to the child or youth?					
Name			Relationship		
<b>If you are not interested in a specific child or youth, do you have any preferences?</b>					
Age Range:		Number of Children or Youth:		Gender: <input type="checkbox"/> Boys <input type="checkbox"/> Girls <input type="checkbox"/>	
No Preference					
<b>Why do you want to foster, adopt, or provide non-certified kinship care for a child or youth*?</b>					

Applicant 1*:						
First Name	Middle Name	Last Name	Maiden/Alias/Other Names Known As			
DOB	SSN	Cell Phone	Email			
Applicant 2*:						
First Name	Middle Name	Last Name	Maiden/Alias/Other Names Known As			
DOB	SSN	Cell Phone	Email			
Other Members of the Household*:						
First Name	Middle	Last Name	DOB	SSN	Relationship to Applicant	Maiden/Alias or Other Name
Household Information						
Type of Residence: <input type="checkbox"/> House <input type="checkbox"/> Townhouse/Condominium <input type="checkbox"/> Apartment						
Do you rent or own your residence? <input type="checkbox"/> Rent <input type="checkbox"/> Own						



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Length of time in current residence*				
Physical Address*:	Street Address	City	State	Zip Code
Mailing Address*: (if different)	Mailing Address	City	State	Zip Code
Home Phone:		School District of Residence:		
Pets in the Home: Specify type and breed: <div style="display: flex; justify-content: space-around;"> <span>Type</span> <span>Breed</span> </div>				
<b>APPLICANT 1*:</b> _____				
<b>Prior Residences in the past 5 years (Including out-of-state and out-of-country):</b>				
Street Address*	City or Town*	State or Country*	Zip Code	Dates of Residence*
<input type="checkbox"/> Male <input type="checkbox"/> Female Gender:		Place of birth:		
<b>Criminal History*</b>				
<p>Have you ever been convicted of, received a deferred prosecution, or deferred judgment for any of the following categories? Please check all that apply. <i>If you checked any of the boxes below, please provide supplemental documentation of the disposition, police report, and any court documents.</i></p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> Felony</div> <div style="width: 25%;"><input type="checkbox"/> Child Abuse</div> <div style="width: 25%;"><input type="checkbox"/> Crime of Violence</div> <div style="width: 25%;"><input type="checkbox"/> Domestic Violence</div> <div style="width: 25%;"><input type="checkbox"/> Drug Offense</div> <div style="width: 25%;"><input type="checkbox"/> Sexual Offense</div> <div style="width: 25%;"><input type="checkbox"/> Registered Sex Offender</div> <div style="width: 25%;"><input type="checkbox"/> Alcohol Offense</div> <div style="width: 25%;"><input type="checkbox"/> Misdemeanor</div> <div style="width: 25%;"><input type="checkbox"/> N/A</div> </div> <p>Please note all crimes, date of the sentencing, town/city/county/state where sentencing occurred, whether you received a conviction/deferred prosecution/deferred judgment, and your name at the time of conviction</p>				
<b>Medical and Mental Health Conditions*</b>				
Have you been diagnosed with or are you being treated for a medical condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please describe		
Have you been diagnosed with or are you being treated for a mental health condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please describe		



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<b>Employment</b>				
(If you have been with current employer less than one year please provide previous employment information, if self-employed please provide information about your business)				
Name of Employer:				
Address of Employer:				
Title of position:				
Gross monthly income:		Dates Employed:		
Name of Employer:				
Address of Employer:				
Title of position:				
Gross monthly income:		Dates Employed:		
Name of Employer:				
Address of Employer:				
Title of position:				
Gross monthly income:		Dates Employed:		
<b>APPLICANT 2*:</b> _____				
<b>Prior Residences in the past 5 years (Including out-of-state and out-of-country):</b>				
Street Address*	City or Town*	State or Country*	Zip Code*	Dates of Residence*
<input type="checkbox"/> Male <input type="checkbox"/> Female   Gender: <span style="margin-left: 100px;">Place of birth:</span>				
<b>Criminal History*</b>				
Have you ever been convicted of, received a deferred prosecution, or deferred judgment for any of the following categories? Please check all that apply. If you checked any of the boxes below, please provide supplemental documentation of the disposition, police report, and any court documents."				
<input type="checkbox"/> Felony <input type="checkbox"/> Child Abuse <input type="checkbox"/> Crime of Violence <input type="checkbox"/> Domestic Violence				
<input type="checkbox"/> Drug Offense <input type="checkbox"/> Sexual Offense <input type="checkbox"/> Registered Sex Offender <input type="checkbox"/> Alcohol Offense				
<input type="checkbox"/> N/A				
Please note all crimes, date of the sentencing, town/city/county/state where sentencing occurred, whether you received a conviction/deferred prosecution/deferred judgment, and your name at the time of conviction				
<b>Medical and Mental Health Conditions*</b>				
Have you been diagnosed with or are you being treated for a medical condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, describe		



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Have you been diagnosed with or are you being treated for a mental health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, describe
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**Employment**  
(If you have been with current employer less than one year please provide previous employment information, if self-employed please provide information about your business)

Name of Employer:  
Address of Employer:  
Title of position:  
Gross monthly income: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Name of Employer:  
Address of Employer:  
Title of position:  
Gross monthly income: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

Name of Employer:  
Address of Employer:  
Title of position:  
Gross monthly income: \_\_\_\_\_ Dates Employed: \_\_\_\_\_

**Other Members of the Household\***

**Criminal History\***

Have other members of the household ever been convicted of, received a deferred prosecution, or deferred judgment for any of the following categories? If yes, please check all that apply. If you checked any of the boxes below, please provide supplemental documentation of the disposition, police report, and any court documents."

Felony       Child Abuse       Crime of Violence       Domestic Violence  
 Drug Offense       Sexual Offense       Registered Sex Offender       Alcohol Offense  
 Misdemeanor       N/A

Please note all crimes, date of the sentencing, town/city/state where sentencing occurred, whether the person received a conviction/deferred prosecution/deferred judgment, and his/her name at the time of conviction

**Prior Residences in the past 5 years (Including out-of-state and out-of-country)\*:  
Attach additional information as needed**

Name*	Street Address*	City or Town*	State or Country*	Zip Code*	Dates of Residence*



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Medical and Mental Health Conditions*			
Have other members of the household been diagnosed with or been treated for a medical condition?	Yes	No	- If yes, describe  Name                      Describe condition  Name                      Describe condition
Have other members of the household been diagnosed with or been treated for a mental health condition?	Yes	No	- If yes, describe  Name                      Describe condition  Name                      Describe condition
History of Placement of Children and Youth with Other Members of the Household			
	Yes	No	If yes, list name of household member and agency or county department
Have you ever been licensed for childcare?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been certified for foster care?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been denied a license for childcare?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been denied a certificate for foster care?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a home study that was not approved?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you applied to another agency to foster or adopt a child or youth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you previously adopted a child or youth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever cared for a child or youth placed in your home other than your own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Court <input type="checkbox"/> Agency Name: Agency Address: <input type="checkbox"/> Other: Explain who placed the child or youth in your home and the circumstances:
Other Children of Applicant 1 and Applicant 2 Not Living in the Household			
Name	Date of Birth	Phone	Address/Email



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Name	Date of Birth	Phone	Address/Email
Name	Date of Birth	Phone	Address/Email
Name	Date of Birth	Phone	Address/Email
Name	Date of Birth	Phone	Address/Email
Name	Date of Birth	Phone	Address/Email

### Applicant 1

#### Marital/Partnership/Civil Union History

Date of Marriage or Civil Union or Length of Partnership	State Where Marriage/Civil Union Occurred	Reason for Ending	Verification of Marriage, Civil Union, or Divorce	Name of former spouse/partner
			Yes    No	
			Yes    No	
			Yes    No	
			Yes    No	

### Applicant 2

#### Marital/Partnership/Civil Union History

Date of Marriage or Civil Union or Length of Partnership	State Where Marriage/Civil Union Occurred	Reason for Ending	Verification of Marriage, Civil Union, or Divorce	Name of former spouse/partner
			Yes    No	
			Yes    No	
			Yes    No	
			Yes    No	

### Finances To Meet Monthly Needs



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Assets: Regular income and available savings and investments, personal property, equipment, real estate other than home, etc.			
Item	Amount	Item	Amount
Monthly Liabilities and credit card balances (with exception of your primary home): Other real estate, auto, loans, and credit cards			
Item	Amount	Item	Amount
<b>History of Placement of Children and Youth</b>			
	Yes	No	If yes, list agency or county department
Have you ever been licensed for childcare?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been certified for foster care?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been denied a license for childcare?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been denied a certificate for foster care?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a home study that was not approved?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you applied to another agency to foster or adopt a child or youth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you previously adopted a child or youth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever cared for a child or youth placed in your home other than your own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Court <input type="checkbox"/> Agency Name: Agency Address: <input type="checkbox"/> Other: Explain who placed the child or youth in your home and the circumstances:
<b>Emergency Contacts*</b>			
Name	Relationship	Telephone Number	Email
<b>References</b> (Each applicant should include at least 2 non-relatives who have known you for a year or more)			
<b>Applicant 1</b>			
Name	Mailing Address	Relationship	Phone



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Applicant 2			
Name	Mailing Address	Relationship	Phone

The Colorado Department of Human Services and its agents do not discriminate against any persons on the basis of sex, race, color, national origin, disability, or participation in its programs, services and activities, or in employment.

**Any applicant who knowingly and willfully makes a false statement of any material fact or thing in the application is guilty of perjury in the second degree as defined in Section 18-8-503, C.R.S. and 7.500.312 (12 CCR 2509-6), and upon conviction thereof, shall be punished accordingly.**

The Undersigned hereby applies for a certificate to operate a Foster Care Home under 26-6-101 et seq. C.R.S. or to adopt a child(ren) or youth in the custody of a county department of human or social services child placement agencies (CPAs) and certifies to the following facts:

Foster Care, Kinship Foster Care, and Adoption:

1. Any information given in the questions that follow shall be correct to the best of my (our) ability.
2. I (we) understand that an investigation must be completed before a certificate can be issued for foster care, or approval for the purpose of adoption can be made, and I (we) shall cooperate with the department of human or social services in the investigation in order for the county department or CPA) to determine conformity with the regulations.
3. I (we) understand that signature of this application constitutes permission for county departments of human or social services or CPA to release information regarding denials of licenses, certificates, and prior adoption approvals or denials.
4. I (we) are aware that a certificate for foster care is time-limited and, if issued, will designate the number and age of children or youth for which care can be given. I (we) understand that if I (we) fail to maintain the rules and regulations, the certificate is subject to suspension or revocation. I (we) are aware that an approval for adoption will designate the number and age of child(ren) for which I (my/our family) am (is) approved to adopt.
5. I (we) hereby give authorization to the county department of human or social services or CPA to obtain reports of child abuse or neglect in all states of residence for the past 5 years and to review records and reports maintained on the state automated system for the applicant(s). Applicants shall sign for their minor children living in their home.
6. Members of the household who are not applicants shall be asked to sign an authorization for the county department of human or social services or CPA to obtain reports of child abuse or neglect and review records and reports maintained on the statewide automated information system.





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- I (we) understand that the applicant or any adult of 18 years of age or older who resides in the home is required to submit a complete set of fingerprints to the Colorado Bureau of Investigation and the Federal Bureau of Investigation, and all costs shall be borne by the applicant or person who resides in the home.

**Foster Care or Kinship Foster Care:**

- I (we) understand that before a certificate can be issued I (we) are required to be fully familiar with the Rules Regulating Foster Care Homes issued by the Colorado Department of Human Services, and I (we) agree to fully comply with them.
- I (we) understand that only one CPA or county department of human or social service can certify our home.
- I (we) understand that I (we) must attend required training prior to certification.
- I (we) understand that I (we) may be subject to immediate adverse action to my (our) certificate or approval for adoption as set forth in Section 26-6-107.7 et seq., C.R.S. as described by rule of the State Board of Human Services.

**1. SIGN THIS SECTION IF APPLYING FOR NON-CERTIFIED KINSHIP CARE\*:**

DATE:	SIGNATURE OF APPLICANT 1:	SIGNATURE OF APPLICANT 2:
_____	_____	_____

**2. SIGN THIS SECTION IF APPLYING FOR FOSTER CARE OR KINSHIP FOSTER CARE CERTIFICATION:**

DATE:	SIGNATURE OF APPLICANT 1:	SIGNATURE OF APPLICANT 2:
_____	_____	_____

**3. SIGN THIS SECTION IF APPLYING FOR APPROVAL FOR ADOPTION:**

The undersigned hereby applies to adopt a child(ren) or youth in the custody of a county department of human or social services and certifies to the following facts:

In accordance with P.L. 110-351, I (we) understand that I (we) am (are) eligible to apply for an adoption tax credit, if I (we) finalize an adoption of a child or youth in the custody of the county department of human or social services.

DATE:	SIGNATURE OF APPLICANT 1:	SIGNATURE OF APPLICANT 2:
_____	_____	_____

**Upon receipt of this application, the county department of human or social services has received verification of citizenship (Birth Certificate) or proof of lawful residency for each applicant.**



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### Applicant 1

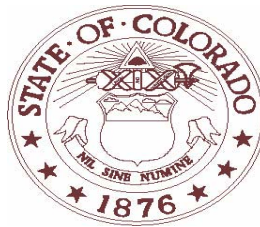
- I am a United States Citizen, or
- I am a legal Permanent Resident of the United States, or
- I am lawfully present in the United States pursuant to federal law

### Applicant 2

- I am a United States Citizen, or
- I am a legal Permanent Resident of the United States, or
- I am lawfully present in the United States pursuant to federal law

DATE:                      SIGNATURE OF DEPARTMENT DESIGNEE:

\_\_\_\_\_



### AFFIDAVIT

Colorado Department of Human Services and the Department of Health Care Policy and Financing as Proof of Lawful Presence in the United States.

I, \_\_\_\_\_, swear or affirm under penalty of perjury under the laws of the State of Colorado that (check one):

- I am a United States Citizen, or
- I am a legal Permanent Resident of the United States, or
- I am lawfully present in the United States pursuant to federal law

I understand that this sworn statement is required by law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.



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Signature \_\_\_\_\_

Date \_\_\_\_\_



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### AFFIDAVIT

DECLARACION / JURAMENTO Departamento de Servicios Sociales del Estado de Colorado y el Departamento de Política y Financiamiento de la Salud Como Prueba de Presencia legal en los Estados Unidos Yo.

\_\_\_\_\_, juro o afirmo bajo pena de perjurio bajo las leyes del  
Estado de Colorado que (cheque uno):

- Soy ciudadano de los Estados Unidos, o
- Soy residente permanente de los Estados Unidos, o
- Estoy legalmente presente en los Estados Unidos conforme a la ley federal.

Yo entiendo que esta declaración jurada es un requerimiento de la ley porque he solicitado ayuda pública. Yo entiendo que las leyes del estado requieren que yo proveé prueba de que Yo estoy presente legalmente en los Estados Unidos antes de que pueda recibir esta ayuda pública. Tambien reconozco que hacer una declaración o representación falsa, ficticia o fraudulenta en esta declaracion jurada es penada bajo la ley criminal de Colorado como perjurio de segundo grado bajo el Estatuto Corregido de Colorado 18-8-503 y constituirá una ofensa criminal separada cada vez que ayuda pública sea fraudulentamente recibida.

Signature \_\_\_\_\_

Date \_\_\_\_\_

