GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

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APPLICATION FOR FAMILY FOSTER HOME

WELCOME!

The Bureau of Social Services Administration (BOSSA) of the Division of Public Welfare, Department of Public Health and Social Services (DPHSS) welcomes your interest in providing care to our foster children. Our children are in foster care because of either physical, emotional, sexual abuse or neglect in their family. Foster parents have an important and rewarding role that will directly impact, nurture and support the child's life while temporarily removed from their homes.

Individuals applying to become foster parents must be U.S. citizens or resident aliens and be residents of Guam (this includes active duty military personnel).

Who May Apply:

- Married Couples
- Domestic Partners (joint or alone)
- Single Persons (including single parents) 18 years or older

If you meet the requirements above, please complete all the documents in the enclosed application packet and submit to the Bureau of Social Services Administration for processing. This will help us in certifying you as a prospective parent.

The application packet includes:

- Application for License
- Autobiography of Foster Parent Form
- Report of Medical History Form and Instruction Sheet (required for each applicant including Tuberculosis Clearance)
- Financial Report Sheet and Instruction Sheet
- Employment Verification Form and Instruction Sheet
- (3) Character Reference Form and Instruction Sheet
- Consent for Disclosure Form
- Social Study Questionnaire

******If you are applying as a couple, please print two copies each of Medical History Form, Consent for Disclosure, Social Study Questionnaire and employment verification if you are both employed.***

Families interested in our foster care program **must** submit the following:

- ☐ Guam Police and Court Clearances***
- ☐ Copy of recent check stub
- ☐ Marriage Certificate/license if applicable
- ☐ Clearance from investigative agency (i.e. Navy Criminal Investigative Services, Offices of Special investigation) if active military personnel)

If you have lived on Guam for less than five years, a child abuse check must be obtained from the state(s) or country/ies you have resided in the past five years. The foster care licensing social worker will assist you with this process.

What to Expect:

A social evaluation of the application and home environment will be conducted by our agency to assess the applicant's personal character, fitness and factors which show competency for the care of foster children.

If an applicant has satisfactorily met the above requirements, the Department will issue a certification showing approval for licensing a family foster home. The license is valid for two years.

We need dedicated families that will meet the challenging needs of our children. We appreciate your time and consideration and we look forward to hearing from you.

You may contact us at:

Mailing Address:
Bureau of Social Services Administration
Division of Public Health and Social Services
194 Hernan Cortez Avenue, Suite 309
Hagatña, Guam 96910-5052

Telephone Numbers:
(671) 475-2672/2653

Facsimile Number:
(671) 477-0500

******Note: Police clearances can be obtained at the:***

Guam Police Department
Records & ID Section
590 South Marine Corps. Drive
ITC Bldg., Ist floor Suite 131
Tamuning, Guam 96913
671-475-8498/8506

Fee: $20.00 each clearance (subject to change)

Court Clearances can be obtained at the:

Superior Court of Guam
120 West O'Brien Drive
Hagatna, Guam 96910
671-475-3274/3121
Fee: $20.00 each clearance (subject to change)

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

APPLICATION FOR FOSTER LICENSE

FAMILY FOSTER HOME (1 – 6 children)

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

Residential Address: _____

Mailing Address: _____

Telephone Number(s): Work:_____ Home:_____ Cell:_____

Work:_____ Home:_____ Cell:_____

E-mail address: _____

B. NUMBER OF CHILDREN TO BE CARED FOR: _____

C. AGE RANGE: _____ **TO** _____

D. GENDER ☐ **Male only** ☐ **Female only** ☐ **Male and Female**

E. Duration: ☐ **Full Time** ☐ **Emergency Foster Care (specify period of care):**_____

F. Are you a permanent resident of Guam? (if not, how long do you plan to stay on Guam?)
☐ **Yes** ☐ **No** **Duration on Guam):**_____

G. If you have been on Guam for less than five (5) years, please provide last know address(es):

Date of Residency:	Address:

H. Have you previously been licensed to care for foster children? ☐ **Yes** ☐ **No**

City	State	Date of license(s)

_____ _____ _____
PRINT NAME SIGNATURE DATE

_____ _____ _____
PRINT NAME SIGNATURE DATE

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES

AUTOBIOGRAPHY OF FOSTER PARENT

NAME OF APPLICANT(S):

ADDRESS:

TELEPHONE: Home:	**Work:**	**Other:**

I. BACKGROUND

What are your reasons for wanting to be a foster parent? Who initiated the idea of being a foster parent and who is most interested?

What was your upbringing like? (Describe your parents' attitude toward child rearing and your family's relationship to one another).

How much contact do you have with your own family now?

II. COUPLE'S RELATIONSHIP (If applicable)

How are decisions made and who makes them?

As a couple, what are your strengths and weaknesses?

How do you deal with difficult issues when they come up?

III. CHILD REARING

What method(s) of discipline do you practice? Under what circumstances would you apply them?

What behaviors do you expect from children, during meals and playtime?

What behaviors or expectations do you have with regards to teenagers?

IV. RELIGION

What are your feelings on religion or morals? How does it relate to child rearing?

V. CERTIFICATION

I certify that the above is true and correct to the best of my knowledge.

_____ _____

Signature Date

Revised 7/29/11

Home Evaluation and Placement Services
Bureau of Social Services Administration
Division of Public Welfare
Department of Public Health and Social Services

INSTRUCTIONS

FOR

MEDICAL HISTORY REPORT

Below are the instructions for completing the medical history report for an applicant/petitioner/party who may apply for Adoption/Termination of Parental Rights (TPR), Custody, Guardianship, Foster, Child Care Center, Inter-Country Adoption Board (ICAB), United States Citizenship and Immigration Services (USCIS), or Off-Island Request for Placements.

This form is to be completed and certified by a physician.

To ensure the medical history report is complete, please read and follow the instructions below. Please type or print legibly in black or blue ink.

1. Enter the last, first name and middle initial, date of birth, gender, height, weight, eye color, hair color, and body mass index (BMI) of the applicant/petitioner/party requesting the medical history report.

2. Enter the physician's name, telephone number, name and address of the clinic.

3. On the personal history section, the physician must check the applicant's/petitioner's/party's past and/or current medical condition(s) listed. For every condition checked, briefly describe and specify the item number of the condition(s) being described. Use the back of paper if additional space is needed.

4. Answer all questions with Yes or No. Check the appropriate boxes. If "Yes", please specify (i.e., type, frequency, duration, etc).

5. **Physician Certification:** The physician must place a check mark whether the applicant/petitioner/party is free from infectious diseases, in good health and able to provide care to a child, or in poor health and unable to provide care to a child.

Upon completion, the physician must sign and date the medical history report. The physician's signature will certify that the information provided is true, correct and complete to the best of his/her knowledge.

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194 Hernan Cortez Avenue, Suite 309
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Telephone No: (671) 475-2653/2672

MEDICAL HISTORY REPORT

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

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

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

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

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

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

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

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

PHYSICIAN'S CERTIFICATION

I certify that this individual is:

[ ] Free from infectious diseases, in good health and able to provide care to a child

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

_____ _____
Physician's Signature Date

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FINANCIAL REPORT SHEET

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____ _____

Signature *(Applicant)* **Date**

_____ _____

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

Home Evaluation and Placement Services
Bureau of Social Services Administration
Division of Public Welfare
Department of Public Health and Social Services

INSTRUCTIONS

FOR

EMPLOYMENT VERIFICATION SHEET

Below are the instructions for completing the financial report sheet for an applicant/petitioner/party who may apply for Adoption/Termination of Parental Rights (TPR), Custody, Guardianship, Foster, Child Care Center, Inter-Country Adoption Board (ICAB), United States Citizenship and Immigration Services (USCIS), or Off-Island Request for Placement services.

This form is to be completed and certified by the employer.

To ensure the employment verification is complete, please read and follow the instructions below. Please type or print legibly in black or blue ink.

1. Enter the last, first name and middle initial, date of birth of the applicant/petitioner/party requesting the employment verification.

2. Enter the place of employment, telephone number, and address of the employer.

3. Enter the position/title, date of hire of the applicant/petitioner/party.

4. On the employment status, check whether the applicant/petitioner/party is full time, part time or other *(please specify).* Also, check if regular, limited term, seasonal, on-call, contractual or other *(please specify).*

5. Enter the gross monthly income of the applicant/petitioner/party.

Upon completion, the certifying official must enter his/her name, sign, date, position/title and contact number(s). The signature will certify that the information provided is true, correct and complete to the best of his/her knowledge.

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BUREAU OF SOCIAL SERVICES ADMINISTRATION
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910-5052
Telephone No: (671) 475-2653/2672

EMPLOYMENT VERIFICATION

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

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

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

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

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

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

5. Gross Monthly Income: $ _____

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

Certifying Official *(Print Name)*: _____

Signature: _____ Date: _____

Position/Title: _____

Contact Number(s): _____

Home Evaluation and Placement Services
Bureau of Social Services Administration
Division of Public Welfare
Department of Public Health and Social Services

INSTRUCTIONS

FOR

CHARACTER REFERENCE FORM

Writing a character reference is a significant task and can have a substantial impact on whether or not an individual is assessed to be a suitable caretaker of child(ren). **Be honest!** The information provided is an important requirement in the completion of the Adoption/Termination of Parental Rights(TPR), Custody, Foster or Child Care Center social study.

This form is to be filled out by a reference who is a non-relative and has known the individual for at least one (1) year. For Inter-Country Adoption Board (ICAB) cases, reference must know the individual for at least 5 years and must be from a church minister or priest, employer and member of the community.

Only three (3) character references are required and will be accepted for each applicant/petitioner/party.

To ensure the character reference form is complete, please read and follow the instructions below: ***(Pls. PRINT)***

1. Enter the name of the applicant/petitioner/party requesting the character reference.

2. Place a check mark on the type of case requested by the applicant/petitioner/party whether Adoption/TPR, Custody, Foster, or Child Care Center.

3. Answer all the questions fully and accurately. Use an additional sheet of paper if necessary. Indicate the part and the number of the item.

    A. What is your relationship to the applicant/petitioner/party? (i.e., co-worker, friend, priest or pastor, etc)

    B. How long have you known the applicant/petitioner/party? Indicate the years you have known this individual.

    C. How often and where do you meet with the applicant/petitioner/party? Specify if social, business, church, etc.

D. What are your opinions of the applicant/petitioner/party? Describe the individual's character, personality traits, moral values, etc.

E. Have you observed any interactions between the applicant/petitioner/party and the child(ren) involved or any other child(ren)?

[ ] Yes [ ] No

If Yes, please describe in detail your observations of how the applicant/petitioner/party interacts with the child(ren) involved in this case. If no child(ren) is/are involved, describe any observations you have on how the individual relates to child(ren) in general.

F. State your recommendations.

4. **REFERENCE:**

Enter your name with complete residential address**,** contact numbers, (*i.e., home, work and other contact number),* and e-mail address.

Upon completion, read, sign and date the character reference form. Your signature attests that the information provided is true, correct and complete to the best of your knowledge.

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194 Hernan Cortez Avenue, Suite 309
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Telephone No: (671) 475-2653/2672

CHARACTER REFERENCE FORM

Note: Please type or print legibly in black or blue ink.

NAME OF APPLICANT/PETITIONER/PARTY: _____

Type of Case: [ ] Adoption/TPR [ ] Custody [ ] Foster

[ ] Child Care Center

The information submitted in this character reference form will assist the Social Worker in assessing the above-named individual as a suitable caretaker of child(ren).

This form is to be filled out by a reference who is a non-relative and has known the individual for at least one (1) year.

For Inter-Country Adoption Board (ICAB) cases, reference must know the individual for at least 5 years and must be from a church minister or priest, employer and member of the community.

Only three (3) character references are required and will be accepted for each individual.

Answer the following questions below: (*Use an additional sheet of paper if necessary)*

A. What is your relationship to the individual?

_____
_____
_____

B. How long have you known the individual?

_____
_____
_____

C. How often and where do you meet? *(Specify if social, business, church, etc.)*

_____
_____
_____
_____

D. What are your opinions of the above-named individual? *(i.e., character, personality traits, moral values, etc.)*

_____
_____
_____
_____
_____
_____
_____

E. Have you observed any interactions between the above-named individual and the child(ren) involved or any other child(ren)? [ ] Yes [ ] No

If Yes, please describe in detail your observation of the interactions.

_____
_____
_____
_____
_____
_____
_____

F. What are your recommendations regarding the individual's intent to serve the best interest of the child(ren) involved or children in general?

_____
_____
_____
_____
_____
_____
_____

REFERENCE:

NAME: _____

RESIDENTIAL ADDRESS: _____
_____

CONTACT NUMBERS: Home: _____
Work:: _____
Other: _____

E-MAIL ADDRESS: _____

THE INFORMATION GIVEN BY ME IN THIS CHARACTER REFERENCE FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature **Date**

Home Evaluation and Placement Services
Bureau of Social Services Administration
Division of Public Welfare
Department of Public Health and Social Services

INSTRUCTIONS

FOR

SOCIAL STUDY QUESTIONNAIRE

The Social Study Questionnaire is provided to all applicants/petitioners/parties requiring social studies from the Home Evaluation and Placement Services (HEPS) Section. HEPS services may include the processing of social studies for Adoption/Termination of Parental Rights (TPR), Custody, Guardianship, Inter-Country Adoption Board (ICAB), U.S. Citizenship and Immigration Services (USCIS), or Off-Island Request for Placements. This questionnaire will help the social worker gather and complete the required social study report pertinent to the requested services.

To ensure the questionnaire is complete, please read the instructions below:

A. PERSONAL INFORMATION

Enter the legal last name, first, and middle name (***Please PRINT***). Enter the date of birth, age, place of birth with city and state, citizenship, ethnicity, social security number *(optional),* home and work contact numbers, e-mail address, complete residential and mailing address.

B. NAME OF CHILDREN

Please list down all the names of your natural/adopted children. Provide all required information on your children such as date of birth, name of school, grade, work place *(if applicable)*, occupation, and residential address with city and state.

C. MARITAL BACKGROUND

Place a check mark in the appropriate boxes and answer question where applicable.

D. FAMILY BACKGROUND

1) Father

Enter the name of your father (***Please PRINT***) and write his age. Place a check mark in the appropriate box. Answer questions

where applicable. Write the complete residential address and occupation.

2) Mother

Enter the name of your mother (***Please PRINT***) and write her age. Place a check mark in the appropriate boxes. Answer questions where applicable. Write the complete residential address and occupation.

3) Siblings *(Brothers and Sisters)*

Please list all the names of your siblings from oldest to youngest. Use an additional sheet of paper if necessary (***Please PRINT***). Indicate the part and the number of the item. Enter the age, marital status, number of children, place of residency, and occupation. Place a check mark in the appropriate box. Answer questions where applicable.

E. EDUCATIONAL BACKGROUND

Enter your last grade completed, when, and where. Indicate the post secondary education, address with city and state, and when. Enter name of college or university, degree earned, when completed, address with city and state.

F. EMPLOYMENT BACKGROUND

List your employment history starting with the most recent. Include the name of business or government agency, address with city and state, position title, contact number, and length of employment.

G. MILITARY HISTORY

Place a check mark in the appropriate box. Answer questions where applicable. Enter the date of enlistment, years of service, date and type of discharge or retirement, and rank.

H. RELIGION BACKGROUND

Enter your religious affiliation and what religious activities do you participate in. Place a check mark in the appropriate box. Answer questions where applicable.

I. CRIMINAL HISTORY

In this area, answer all required questions. Place a check mark in the appropriate boxes. Answer questions for all boxes checked “Yes”.

J. HOUSEHOLD COMPOSITION

Please identify all persons living in the home *other* than you and your children. List their names, dates of birth and their relationship to you. Use an additional sheet of paper if necessary. Indicate the part and the number of the item.

Upon completion, read, sign and date the questionnaire. Your signature attests that the information provided is true, correct and complete to the best of your knowledge.

Should you have any questions, please contact your assigned Social Worker at (671) 475-2653/2672.

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DIVISION OF PUBLIC WELFARE
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Telephone No: (671) 475-2653/2672

SOCIAL STUDY QUESTIONNAIRE

Note: Please type or print legibly in black or blue ink.

A. Personal Information: Legal Name: (Last):	(First):	(Middle):
Date of Birth:	Age:	
Place of Birth – City & State:		
Citizenship:	Ethnicity:	
Social Security Number *(Optional)*		
Home Phone No:	Work No:	
E-mail Address:		
Residential Address:		
Mailing Address:		

B. Name of Children: Please list names of your natural/adopted children from oldest to youngest. Use an additional sheet of paper if necessary:	
1. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
2. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
3. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
4. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
5. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
6. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	

Residential Address: (City & State)	
7. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
8. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
9. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	
10. Name:	Date of Birth:
Name of School:	Grade:
Work Place, *if applicable*:	
Occupation:	
Residential Address: (City & State)	

C. <u>Marital Background:</u>

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated
If other than married**,** are you presently in a relationship? [ ] Yes [ ] No
If married, is this your first marriage? [ ] Yes [ ] No
If No, number of previous marriages: _____

D. <u>Family Background:</u>

Name of Father:

Age:	Is Father still living? [ ] Yes [ ] No
If No, please indicate the date, age and cause of death:	
Residential Address of Father:	
Occupation:	

Name of Mother:

Age:	Is Mother still living? [ ] Yes [ ] No
If No, please indicate the date, age and cause of death:	
Residential Address of Mother:	
Occupation:	
Are your parents married? [ ] Yes [ ] No	
If Yes, how many years have your parents been married?	
If No, how many years have they been divorced or in a relationship?	
If divorced, did they remarry? [ ] Yes [ ] No	

Siblings (*Brothers and Sisters)* - Please list the names of your siblings from oldest to youngest. Use an additional sheet of paper if necessary:

1. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	

2. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
3. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
4. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
5. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
6. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
7. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
8. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
9. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
10. Name:	Age:
Marital Status:	No. of children:
Place of residency:	Occupation:
Deceased [ ] Alive [ ] If deceased, cause of death:	
E. <u>Educational Background:</u>	
Last Grade completed:	When:
Where:	
Post Secondary Education:	
Address (City & State):	
Name of College or University:	
Degree earned:	When completed:
Address (City & State):	
Name of College or University:	
Degree earned:	When completed:
Address (City & State):	
Name of College or University:	
Degree earned: none	When completed:

F. Employment Background:

Please list employment history starting with the most recent:

1. Name of Business or Govt. Agency:

Address (City & State):

Position Title:

Contact No:

Length of Employment:

2. Name of Business or Govt. Agency:

Address (City & State):

Position Title:

Contact No:

Length of Employment:

3. Name of Business or Govt. Agency:

Address (City & State):

Position Title:

Contact No:

Length of Employment:

4. Name of Business or Govt. Agency:

Address (City & State):

Position Title:

Contact No:

Length of Employment:

5. Name of Business or Govt. Agency:

Address (City & State):

Position Title:

Contact No:

Length of Employment:

G. Military History:

Have you ever enlisted in the United States Military? [ ] Yes [ ] No

If Yes, what branch of military?

Date of Enlistment :	Years of Service:	
Date of Discharge or Retirement:	Type of Discharge:	Rank:

H. Religion Background:

What is your religious affiliation?

What religious activities do you participate in?
Sunday services and Wednesday bible study

Do you encourage your children to practice your religion? [ ] Yes [ ] No

I. Criminal History:

Do you have a history as an offender of Substance Abuse, Sexual Abuse, Child Abuse, and/or Family Violence? [ ] Yes [ ] No
If Yes, please provide dates and places:

Have you ever been ***arrested*** of Substance Abuse, Sexual Abuse, Child Abuse, and/or Family Violence? [ ] Yes [ ] No
If Yes, please provide dates and places:

Have you ever been ***convicted*** of Substance Abuse, Sexual Abuse, Child Abuse, and/or

Family Violence? [ ] Yes [ ] No
If Yes, please provide dates and places:

Have you and/or your spouse *(if applicable)* ever been a subject of an unfavorable social study?
[ ] Yes [ ] No
If Yes, provide dates and places:

J. <u>Household Composition:</u>

Please list all persons living in the home <u>*other*</u> than you and your children. Use an additional sheet of paper if necessary:

Name	Date of Birth	Relationship

THE INFORMATION GIVEN BY ME IN THIS SOCIAL STUDY QUESTIONNAIRE FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

FAILURE TO DISCLOSE OR COOPERATE ON THE INFORMATION PROVIDED ABOVE MAY RESULT IN AN INCOMPLETE SOCIAL STUDY REPORT.

_____ _____
Signature of Applicant/Petitioner/Party **Date**

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

LOURDES A. LEON GUERRERO
GOVERNOR, MAGA'HÅGA'

JOSHUA F. TENORIO
LT. GOVERNOR, SIGUNDO MAGA'LÅHI

LAURENT SF DUENAS, MPH, BSN
ACTING DIRECTOR

JOSEPHINE T. O'MALLAN
DEPUTY DIRECTOR

BUREAU OF SOCIAL SERVICES ADMINISTRATION
DIVISION OF PUBLIC WELFARE

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

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

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

The client may revoke this Consent for Disclosure of Client Information at any time. This Consent shall be effective immediately and shall remain in effect until (date): ___	
_____ Signature of Client/Guardian/Parent Date: _____	_____ Signature of Person Requesting Information Date: _____
I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE PERSON OR ORGANIZATION ABOVE AS OF: _____	
_____ Signature of Client/Guardian/Parent	_____ Date: