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 Children's Wellness, 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 they are temporarily removed from their homes.

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

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 (BOSSA) for processing. This will help us in certifying you as a prospective foster parent.

The application packet includes:

- Application for License
- Autobiography of Foster Parent Form (one per applicant)
- Social Study Questionnaire (one per applicant)
- Medical History Form for each applicant. NOTE: A **Tuberculosis Clearance must be provided for all household members.**
- Financial Report Sheet
- Employment Verification Form (one for each employed applicant)
- Three (3) Character Reference Forms
- Consent for Disclosure Form for Child Abuse and Neglect Registry (CAN) check

******If you are applying as a couple, please print two copies of the Medical History Form, Social Study Questionnaire, Autobiography, and Employment Verification Form if you are both employed. A Consent for Disclosure Form for a CAN registry check is needed for each adult household member. An application packet is also available at the BOSSA office.***

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

- Birth Certificate
- Photo ID or passport
- Social Security Card
- Copy of last two (2) pay check stubs
- Marriage Certificate/license if applicable

If you have lived on Guam for less than five years, a Child Abuse and Neglect (CAN) check must be obtained from all states and countries you have resided in the past five years. The licensing social worker will assist you with this process.

The licensing social worker can obtain a police and court clearance for all applicants and adult household members with their consent. The licensing social worker will provide the consent form for both clearances which must include the individual's full legal name.

The licensing social worker will also obtain a military clearance from, if applicable.

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 of a family foster home. The license is valid for two years.

NOTE: When an applicant submits a foster care application, he/she has ninety (90) days to complete all licensing requirements, otherwise your application will be voided. If you are still interested in becoming a licensed foster parent, you must re-apply.

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:

Bureau of Social Services Administration
194 Hernan Cortez Avenue, Suite 309
Hagatña, Guam 96910-5052
Office: (671) 475-2672/2653
Email: bossa@dphss.guam.gov

BUREAU OF
SOCIAL SERVICES
ADMINISTRATION

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

DIVISION OF CHILDREN'S WELLNESS
BUREAU OF SOCIAL SERVICES ADMINISTRATION

APPLICATION FOR FAMILY FOSTER HOME LICENSE

☐ NEW APPLICATION

☐ RENEWAL APPLICATION

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

Residential Address: _____

Mailing Address: _____

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

Work:_____ Home:_____ Cell:_____

E-mail address: _____

B. Are you 18 years old or older? ☐ Yes ☐ No

C. Are you a U.S. Citizen? ☐ Yes ☐ No If not, are you a Resident Alien? ☐ Yes ☐ No

D. Are you a permanent resident of Guam? ☐ Yes ☐ No If not, how long do you plan to stay on Guam? _____

E. If you have been on Guam for less than five (5) years, please provide the following information:

Dates of Residency:	Physical Address:

F. NUMBER OF CHILDREN YOU WISH TO FOSTER: ____ (6 children max. unless approved by the Bureau)

G. AGE RANGE: _____ TO _____

H. GENDER: ☐ Male Only ☐ Female Only ☐ Male and Female

I. DURATION: ☐ Full Time ☐ Emergency Foster Care (specify length of care): _____

J. **Criminal History:**

Have you ever been convicted of a felony? ☐ Yes ☐ No
If yes, what was the offense? _____

Do you have a history as an offender of Substance Abuse, Sexual Abuse, Child Abuse or Neglect, or Family Violence? ☐ Yes ☐ No If yes, please provide the type of offense and dates:

_____

Have you ever been investigated for Substance Abuse, Sexual Abuse, Child Abuse or Neglect, or Family Violence? ☐ Yes ☐ No If yes, please provide the type of offense and dates:

_____

Have you ever been arrested for a Drug or Alcohol related crime, Criminal Sexual Conduct, Child Abuse or Neglect, or Family Violence? ☐ Yes ☐ No If yes, please provide the type of offense and dates:

_____

Have you ever been convicted of a Drug or Alcohol related crime, Criminal Sexual Conduct, Child Abuse or Neglect, or Family Violence? ☐ Yes ☐ No If yes, please provide the type of offense and dates:

_____

K. 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 CHILDREN'S WELLNESS
BUREAU OF SOCIAL SERVICES

AUTOBIOGRAPHY OF FOSTER PARENT

NAME OF APPLICANT:		
ADDRESS:		
TELEPHONE: Home:	**Work:**	**Cell:**

I. BACKGROUND

What are your reasons for wanting to be a foster parent? If applying as a couple, 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 6/2/21

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF SOCIAL SERVICES ADMINISTRATION
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910-5052
Telephone No: (671) 475-2653/2672

BUREAU OF SOCIAL SERVICES ADMINISTRATION

SOCIAL STUDY QUESTIONNAIRE

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

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

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:	*When completed:*
F. <u>Employment Background:</u> *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:

G. <u>Military History:</u>

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. <u>Religion Background:</u>

What is your religious affiliation?

What religious activities do you participate in?

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

I. <u>Criminal History:</u>

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

*Have you ever been **arrested** for a Drug-Related Crime, Criminal Sexual Conduct, Child Abuse or Neglect, and/or Family Violence? [ ] Yes [ ] No*
If Yes, please provide dates and places:

*Have you ever been **convicted** of a Drug-Related Crime, Criminal Sexual Conduct, Child Abuse or Neglect, 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. Household Composition:

Please list all persons living in the home other 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 **Date**

HOME EVALUATION AND PLACEMENT SERVICES
BUREAU OF SOCIAL SERVICES ADMINISTRATION
DIVISION OF CHILDREN'S WELLNESS
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910-5052

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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 Children's Wellness
Department of Public Health and Social Services

DIVISION OF CHILDREN'S WELLNESS
BUREAU OF SOCIAL SERVICES ADMINISTRATION

INSTRUCTIONS

FOR

FINANCIAL REPORT 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 by the applicant/petitioner/party.

To ensure the financial report sheet is complete, please read and follow the instructions below. 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.

There are two types of Income:

A. **Earned Income:** Income received in exchange for an individual's physical or mental labor including, but not limited to, the following:

- 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:** An individual's income from sources other than employment, work, effort or any other contribution from persons including, but not limited to, the following:

- Social Security Benefits

- Retirement
- Child Support
- Alimony
- Welfare
- Food Stamps
- WIC
- Contribution from Persons, etc.

1. Enter the last, first name and middle initial of the applicant/petitioner/party (and co-applicant's if applicable).

2. List the source(s) of and monthly gross income.

3. Enter the sub-totals and total amount of income.

II. ASSETS:

1. List all types of assets including, but not limited to: Checking, Savings, TCD/Money Market. If other, please specify.

2. Indicate the owner(s) of the account(s) by checking the appropriate boxes (applicant, co-applicant or joint).

3. Enter the name of the financial institution and current balance for each account.

4. Enter the total amount of assets.

III. MONTHLY EXPENSES:

A. Creditors:

1. List your monthly expenses (and co-applicant's if applicable) including, but not limited to: Mortgages, Auto Loans, Personal Loans, Credit Cards (Master Card, Visa, American Express. Department Store Cards, Gas cards, etc). If other, please specify.

2. Enter the name of creditors.

3. Enter the remaining balances and the monthly payments.

4. Enter the total amount of remaining balances and monthly payments to creditors.

B. Living Expenses:

1. Indicate your monthly expenses (and co-applicant's if applicable) including, but not limited to: Rent, Medical Insurances, Dental Insurances, Home Insurances, Auto Insurances, Life Insurances, Power, Water, Telephone/Cell Phone, Internet, Cable, Tipping Fee, Tuition/Child Care, Groceries. If other, please specify.

2. Enter the average monthly payments.

3. Enter the total amount of living expenses.

IV. CERTIFICATION: Upon completion, the applicant/petitioner/party (and co-applicant if applicable) must sign and date. The signature will certify that the information provided is true, correct and complete to the best of your knowledge.

HOME EVALUATION AND PLACEMENT SERVICES
BUREAU OF SOCIAL SERVICES ADMINISTRATION
DIVISION OF CHILDREN' WELLNESS
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910-5052
Telephone No: (671) 475-2653/2672

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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/No. of hours:_____
[ ] Part Time/No. of hours:_____
[ ] 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
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF SOCIAL SERVICES ADMINISTRATION
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
194 Hernan Cortez Avenue, Suite 309
Hagatna, Guam 96910

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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			Date and results of PPD:
5	Heart Disease			
6	Hepatitis			
7	Auto-Immune Disorder			
8	Depression			
9	Anxiety			
10	Kidney Disease			
11	Skin Disease			
12	Seizure Disorders			
13	Mental Illness			
14	Stomach/Intestinal Disorders			
15	Head Injuries			
16	Fractures			
17	Hearing Impairment			
18	Vision Impairment			
19	Thyroid Disease			
20	Lung Disease			
21	Asthma			
22	Allergies			
23	Organ Transplant			
24	Stroke			
25	Pacemaker			
26	Degenerative Muscular Disorder			
27	Other(s):			

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

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

PHYSICIAN'S CERTIFICATION

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

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

_____ _____
Physician's Signature Date

Revised: 3/27/24

Home Evaluation and Placement Services
Bureau of Social Services Administration
Division of Children's Wellness
Department of Public Health and Social Services

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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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Hagatna, Guam 96910-5052
Telephone No: (671) 475-2653/2672

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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

BUREAU OF SOCIAL SERVICES ADMINISTRATION

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.

GOVERNMENT OF GUAM

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

BUREAU OF SOCIAL SERVICES ADMINISTRATION
DIVISION OF CHILDREN'S WELLNESS

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION
CHILD ABUSE AND NEGLECT REGISTRY CHECK

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: CHILD PROTECTIVE SERVICES
2. Name of Person or Organization to Receive Information: HOME EVALUATION AND PLACEMENT SERVICES (HEPS)
3. Name of Client (Print Name) and Date of Birth:
4. Purpose or Need for the Disclosure (Please be very specific): Child Abuse and Neglect registry check
5. Extent or Nature of Information to be Disclosed (Please be very specific): Record of all referrals of child abuse and/or neglect on the client, to include the type of maltreatment, CPS findings, and disposition of case.

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

Revised: 8/12/24