

## Joint Court Ordered Kinship Care and Foster Care Application

**Use of form:** Use of this form is voluntary; however its completion meets the requirements of s.48.57(3m) of the Wisconsin Statutes. This form may be used for all court ordered Kinship Care applicants pursuing Foster Care Licensure. Personally identifiable information collected on this form is confidential and will be used for identification and determination of eligibility for a payment only. Provision of your social security number (SSN) is voluntary; not providing it could result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Complete the first page for each child that you are requesting Kinship Care reimbursement. The application includes space for two caregivers, in the case that you have additional caregiver applicants, you may attach additional sections. The agency will also provide forms for background checks required for both the Kinship Care and Foster Care programs. For more information or for assistance filling out this form, please contact the person who provided this form to you.

### I. CHILD IN PROVIDER'S CARE (LICENSURE REQUEST)

Name – Child (Last, First, MI)		Birthdate (mm/dd/yyyy)	Social Security Number	
Date of Court Order (mm/dd/yyyy)	eWiSACWIS Case Number		Court Case Number	

Yes  No Does the child receive social security income (SSI) on his or her **own** behalf?  
If "Yes", he or she is ineligible for Kinship Care payment.

Ethnicity (Check at least one box and may check up to three boxes)

- |   |   |
|---|---|
| <input type="checkbox"/> White                            | <input type="checkbox"/> Asian                              |
| <input type="checkbox"/> Black / African-American         | <input type="checkbox"/> Native Hawaiian / Pacific Islander |
| <input type="checkbox"/> American Indian / Alaskan Native | <input type="checkbox"/> Other                              |

Relationship to caregiver		Date began living with caregiver (mm/dd/yyyy)		
<b>Name – Parent 1</b> of Minor Relative		Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street		City	State	Zip Code
<b>Name – Parent 2</b> of Minor Relative		Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street		City	State	Zip Code

**II. CAREGIVER(S)**

**CAREGIVER 1** Name (Last, First, MI)  Yes  No Are you a Wisconsin resident?  
If "Yes", for how long?

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell
-------------------------	-------------------------	-------------------------

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a relative of the child? If "Yes", specify relationship:	Driver's License Number and State
--	-----------------------------------

Current Address – Street	City	State	Zip Code
--------------------------	------	-------	----------

Mailing Address if Different Than Above

**Previous Addresses for Last 5 Years (Including Out-of-State or Country)**

Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code
Address – Street	City	State	Zip Code

Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No Hispanic or Latino / Latina
------------------------	---	------------------------	--

Ethnicity (Check at least one box and may check up to three boxes)

<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> Black / African-American	<input type="checkbox"/> Native Hawaiian / Pacific Islander
<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Other

Marital Status

<input type="checkbox"/> Single – never married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married – living together	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married – but separated	

General Health Status  
 Yes  No Do you have family medical insurance? If "Yes", provide the company name.

Describe your current health status and any conditions you receive or have received treatment for.

List current medications and reason for use.

List all hospitalizations, reasons, and dates.

**Educational Level**

\_\_\_\_\_ Enter highest level of education attained.

- 01 to 11 Grade level completed in primary / secondary school. Enter last grade completed.
- 12 High school diploma, GED or National External Diploma Program
- 13 Awarded Associate's Degree
- 14 Awarded Bachelor's Degree
- 15 Awarded Graduate Degree (Master's or higher)
- 16 Other credentials (degree, certificate, diploma, etc.)
- 98 No formal education

**Military Service**

Yes  No Have you ever been in the military? If "Yes", which branch:

Date of Enlistment (mm/dd/yyyy)      Date of Discharge (mm/dd/yyyy)      Type of Discharge

**Current Employment Status**

Employed     Unemployed     Not in labor force (not looking for work, retired, disabled, etc.)

Occupation / job title:

Current employer:

Employer address (Street, City, State, Zip Code):

Date employment began (mm/dd/yyyy):

Duties:

Yes  No Do you have a retirement plan?

Working hours and days of week:

**Employment History (Previous 10 years)**

Employer	Position	Duties	Dates of Employment	Reason for Leaving

**Current Income (Include all sources of public assistance or social security)**

Total Monthly Income: \$ \_\_\_\_\_

Child Support: \$ \_\_\_\_\_     Maintenance: \$ \_\_\_\_\_     Unemployment: \$ \_\_\_\_\_

Adoption Assistance: \$ \_\_\_\_\_     Kinship Care: \$ \_\_\_\_\_  
From which agency? \_\_\_\_\_

SSI: \$ \_\_\_\_\_     SSD: \$ \_\_\_\_\_     SSA: \$ \_\_\_\_\_

Supplemental: \$ \_\_\_\_\_

---

Foster Care Licensing History

Yes  No Have you ever applied for or been granted a foster care or other child care license?

Name of Licensing Agency	Type	Date of Application	Period of Licensure	Closing Reason

Yes  No Have you ever had a license or certification revoked?

If "Yes", provide date, reason and revoked by which agency.

---

Yes  No Have you ever applied for adoption?

If "Yes", please elaborate.

<b>CAREGIVER 2</b> Name (Last, First, MI)	<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a Wisconsin resident? If "Yes", for how long?
---	---

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell
-------------------------	-------------------------	-------------------------

<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a relative of the child? If "Yes", specify relationship:	Driver's License Number and State
--	-----------------------------------

Current Address – Street	City	State	Zip Code
--------------------------	------	-------	----------

Mailing Address if Different Than Above

**Previous Addresses for Last 5 Years (Including Out-of-State or Country)**

Address – Street	City	State	Zip Code
------------------	------	-------	----------

Address – Street	City	State	Zip Code
------------------	------	-------	----------

Address – Street	City	State	Zip Code
------------------	------	-------	----------

Address – Street	City	State	Zip Code
------------------	------	-------	----------

Address – Street	City	State	Zip Code
------------------	------	-------	----------

Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	<input type="checkbox"/> Yes <input type="checkbox"/> No Hispanic or Latino / Latina
------------------------	---	------------------------	--

Ethnicity (Check at least one box and may check up to three boxes)

<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> Black / African-American	<input type="checkbox"/> Native Hawaiian / Pacific Islander
<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Other

Marital Status

<input type="checkbox"/> Single – never married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married – living together	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married – but separated	

General Health Status

Yes  No Do you have family medical insurance? If "Yes", provide the company name.

Describe your current health status and any conditions you receive or have received treatment for.

List current medications and reason for use.

List all hospitalizations, reasons, and dates.

Educational Level

- \_\_\_\_\_ 01 to 11 Grade level completed in primary / secondary school. Enter last grade completed.  
12 High school diploma, GED or National External Diploma Program  
13 Awarded Associate's Degree  
14 Awarded Bachelor's Degree  
15 Awarded Graduate Degree (Master's or higher)  
16 Other credentials (degree, certificate, diploma, etc.)  
98 No formal education

Military Service

Yes  No Have you ever been in the military? If "Yes", which branch:

Date of Enlistment (mm/dd/yyyy)	Date of Discharge (mm/dd/yyyy)	Type of Discharge

Current Employment Status

Employed  Unemployed  Not in labor force (not looking for work, retired, disabled, etc.)

Occupation / job title:

Current employer:

Employer address (Street, City, State, Zip Code):

Date employment began (mm/dd/yyyy):

Duties:

Yes  No Do you have a retirement plan?

Working hours and days of week:

Employment History (Previous 10 years)

Employer	Position	Duties	Dates of Employment	Reason for Leaving

Current Income (Include all sources of public assistance or social security)

Total Monthly Income: \$ \_\_\_\_\_

Child Support: \$ \_\_\_\_\_  Maintenance: \$ \_\_\_\_\_  Unemployment: \$ \_\_\_\_\_

Adoption Assistance: \$ \_\_\_\_\_  Kinship Care: \$ \_\_\_\_\_

From which agency? \_\_\_\_\_

SSI: \$ \_\_\_\_\_  SSD: \$ \_\_\_\_\_  SSA: \$ \_\_\_\_\_

Supplemental: \$ \_\_\_\_\_

---

Foster Care Licensing History

Yes  No Have you ever applied for or been granted a foster care or other child care license?

Name of Licensing Agency	Type	Date of Application	Period of Licensure	Closing Reason

Yes  No Have you ever had a license or certification revoked?

If "Yes", provide date, reason and revoked by which agency.

---

Yes  No Have you ever applied for adoption?

If "Yes", please elaborate.

### III. HOUSEHOLD (Other non-caregiving adults and children)

List ALL of your biological and / or adopted children whether they live in your home or not.

Name – Last, First, MI (print)	Age	Gender	Birthdate (mm/dd/yr)	Lives in Home	For Those Living in the Home List Any Health Conditions and Medication
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	

List the names and information of ALL OTHER individuals living in your home.

Check if no additional people live in your home.

Name – Last, First, MI (print)	Age	Gender	Birthdate (mm/dd/yr)	Social Security Number	WI Driver's License OR State ID No. (if 18 or older)	Relationship
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				
		<input type="checkbox"/> M <input type="checkbox"/> F				

Yes  No Do you have any pets?

If "Yes", what type and how many?

Yes  No Is the animal(s) up-to-date on vaccinations?

### IV. FINANCIAL

Yes  No Do you have homeowner's or renter's insurance?

If "Yes", provide company name and policy number.

#### Household Monthly Expenses

Rent or mortgage	\$
Heat and utilities	\$
Groceries	\$
Recreation / entertainment	\$
Transportation	\$
Installment purchases	\$
Savings	\$
Clothing	\$
Charitable contributions	\$
Insurance premiums	\$
Medical / dental	\$
Household expenses	\$
Education expenses	\$
Other expenses	\$
<b>Total</b>	\$



---

**V. DESCRIPTION OF CURRENT RESIDENCE**

---

Age of Home	Square Footage	Number of Bedrooms	Number of Bathrooms	Total Number of Rooms
Square Footage of Foster Youth Bedroom		Type of Home (House, apartment, duplex, mobile, town home)		
Type of Plumbing / Septic			<input type="checkbox"/> Yes <input type="checkbox"/> No Plumbing / septic up to code?	
Type of Electrical			<input type="checkbox"/> Yes <input type="checkbox"/> No Electrical up to code?	
Type of Heating / Air Conditioning			<input type="checkbox"/> Yes <input type="checkbox"/> No Heating / air conditioning up to code?	

---

List any repairs that are needed to the home.

---

List any internal hazards (fireplaces, staircases, etc.).

---

List any external hazards (lakes, rivers, busy street, railroad tracks, etc.).

---

List any farm machinery, outbuilding, outside pool or other hazardous machinery.

---

List any firearms or other weapons in the home. Specify how they and any ammunition are stored.

---

**VI. EMPLOYEES OF CAREGIVER RELATIVE WHO WOULD HAVE REGULAR CONTACT WITH CHILD**

1. Name		Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street		City	State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If “Yes”, for how long?				
2. Name		Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street		City	State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If “Yes”, for how long?				
3. Name		Birthdate (mm/dd/yyyy)	Telephone Number – Home	
Address – Street		City	State	Zip Code
<input type="checkbox"/> Yes <input type="checkbox"/> No Wisconsin resident? If “Yes”, for how long?				

**VII. CONFIRMATION**

I, the undersigned Caregiver, attest to the following:

- Neither I, any other adult resident of this household nor any employee who would have regular contact with the minor relative identified above, have any arrests or convictions which would adversely affect the minor relative or my ability to care for the minor relative identified above.
- I will notify the agency prior to the habitation of any other adult in my home and prior to employment of any person who would have regular contact with the minor relative identified above.
- I will contact the agency prior to or within three (3) working days after the minor relative for whom a Kinship Care payment is made leaves my home.
- I will assist the agency to the extent possible in referring the parents of the minor relative identified above to the child support agency.
- I will cooperate with the agency in this application process and the annual review process, including applying for any other financial assistance programs for which the minor relative identified above may be eligible.

If someone other than the applicant(s) has assisted in completing this form, by signing below you acknowledge that it is exactly as stated by applicant(s).

<b>SIGNATURE</b> – Person Other Than Applicant(s) That Assisted In Completing Form	Relationship to Applicant(s)	Date Signed
--	------------------------------	-------------

I attest that the information provided above is truthful and accurate to the best of my knowledge.

<b>SIGNATURE</b> – Caregiver 1	Date Signed
<b>SIGNATURE</b> – Caregiver 2	Date Signed
<b>SIGNATURE</b> – Caregiver 3	Date Signed