



# Host Family Application

Date: \_\_\_\_\_

FAMILY NAME: \_\_\_\_\_

SUPERVISING AGENCY: Twin Cedars Youth and Family Services

ASSESSMENT STAFF: \_\_\_\_\_

STAFF CONTACT PHONE: \_\_\_\_\_

**APPLICANT #1:** Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Birth: \_\_\_\_\_ (Date) \_\_\_\_\_ (Place) Last 4 digits of SS#: \_\_\_\_\_ (for background check)

Race/Ethnicity/Nationality: \_\_\_\_\_ Languages spoken: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Work email: \_\_\_\_\_

**APPLICANT #2:** Last name: \_\_\_\_\_ First name: \_\_\_\_\_

Birth: \_\_\_\_\_ (Date) \_\_\_\_\_ (Place) Last 4 digits of SS#: \_\_\_\_\_ (for background check)

Race/Ethnicity/Nationality: \_\_\_\_\_ Languages spoken: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Work email: \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

### BUSINESS OPERATION ON PREMISES:

Does Applicant operate a business from the residence?  Yes  No

If yes, describe how your home business would impact a hosting: \_\_\_\_\_

### HOME DESCRIPTION: (Check all that apply.)

- Construction:
- Apartment Building
  - Single Family Home
  - One Story
  - Basement
  - Condominium
  - Mobile Home
  - Two or More Stories
  - Other:
  - Duplex
  - Military
  - Bi-Level
- Indoor Space:
- Basement with Walkout
  - Two Bedrooms
  - Handicapped Accessible
  - Attic
  - Three Bedrooms
  - Other:
  - One Bedroom
  - Four or More Bedrooms
- Outside Space:
- Porch
  - Patio
  - Play Equipment
  - Deck
  - Hot Tub
  - Shed/Barn
  - Fenced Yard
  - Handicapped Accessible
  - Pool/Pond/Lake
  - Detached Garage
- Arrangement:
- Rent
  - Own
  - Other:

**Pets, Firearms, and water sources:**

Are there pets in the home?  Yes  No

If yes, do they meet all county/city safety ordinance requirements?  Yes  No

If there are pets in the home, how many pets and what kinds? \_\_\_\_\_

Explain any noncompliance with county/city safety ordinance requirements: \_\_\_\_\_

Are all pets friendly to children?  Yes  No, please explain: \_\_\_\_\_

Are there any firearms or weapons in the home?  Yes  No

If yes, describe the type and purpose for being in the home: \_\_\_\_\_

Where are the firearms stored? \_\_\_\_\_

Water Source:  Municipal  Well  Private

**Home Environment:**

Do you have a swimming pool?  Yes  No If yes, is it fenced in?  Yes  No

Are smoke detectors and carbon monoxide detectors working?  Yes  No

Is water temperature set to avoid burning?  Yes  No

Are cleaning supplies and chemicals out of reach or secured?  Yes  No

Are there any open outlets, etc, that might be harmful?  Yes  No

**Household composition:**

**Include All Individuals Residing in the Home**

(Add additional information on another sheet if needed)

	Name	DOB	RESIDES		RELATIONSHIP TO APPLICANT
1.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
2.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
3.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
4.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
5.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
6.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
7.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
8.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
9.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____
10.	_____	_____	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	_____

**Description of Home-Sleeping Arrangements**

(\*Indicate where children sleep, including Host child)

BEDROOM MEASUREMENTS (Can be measured by SF Staff)	FLOOR/LEVEL	NAME OF OCCUPANTS (If occupied)	TYPES OF BEDS FOR CHILDREN (Crib, single, double, bunk top or bottom)
1. <u>Master Bedroom-</u>	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

**TRANSPORTATION**

Will household vehicles be used to transport children? Yes No

Does the applicant(s) have proof of insurance and a valid driver’s license for vehicles used to transport children?

Yes No, explain: \_\_\_\_\_

Do all other approved household members have proof of insurance and a valid driver’s license for vehicles used to transport children?  Yes No

List all household members approved to transport: \_\_\_\_\_

Describe alternative transportation plan if family does not own operating vehicle: \_\_\_\_\_

**FAMILY BACKGROUND AND HISTORY:** *(Discuss life experience and family relationships, general understanding of the family history, structure, organization, and culture. Has there been any history of domestic violence?)*

**Applicant 1:** \_\_\_\_\_

Which of the following has occurred in your family origin?

- Domestic Violence     Child Abuse     Divorce     Mental Illness     Substance Abuse
- Traumatic Events     Other, please explain: \_\_\_\_\_

**Applicant 2:** \_\_\_\_\_

Which of the following has occurred in your family origin?

- Domestic Violence     Child Abuse     Divorce     Mental Illness     Substance Abuse
- Traumatic Events     Other, please explain: \_\_\_\_\_

**Childhood:** *(Discuss upbringing, family relationship, siblings, family rules.)*

**Applicant 1:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant 2:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Discipline in applicants’ family of origin:**

**Applicant 1:** \_\_\_\_\_

- Time-Outs     Spanking     Loss of privileges     Grounding     Other: \_\_\_\_\_

Was punishment ever excessive?  No  Yes, please explain: \_\_\_\_\_

**Applicant 2:** \_\_\_\_\_

- Time-Outs     Spanking     Loss of privileges     Grounding     Other: \_\_\_\_\_

Was punishment ever excessive?  No  Yes, please explain: \_\_\_\_\_

**Education: (List highest grade/year completed)**

**Applicant 1:** \_\_\_\_\_

High School \_\_\_\_\_ Did you receive a diploma?  Yes  No

College \_\_\_\_\_ List type of degree/diploma/certificate received: \_\_\_\_\_

School Name & Location

Dates Attended

Degree

High School: \_\_\_\_\_

College: \_\_\_\_\_

Graduate: \_\_\_\_\_

Family/friend hobbies, activities, and interests: \_\_\_\_\_

**Applicant 2:** \_\_\_\_\_

High School \_\_\_\_\_ Did you receive a diploma?  Yes  No

College \_\_\_\_\_ List type of degree/diploma/certificate received: \_\_\_\_\_

School Name & Location

Dates Attended

Degree

High School: \_\_\_\_\_

College: \_\_\_\_\_

Graduate: \_\_\_\_\_

Family/friend hobbies, activities, and interests: \_\_\_\_\_

**Current family relationships:**

**Current Marriage:** Marriage Date: \_\_\_\_\_

Number of years married: \_\_\_\_\_ How did you meet? \_\_\_\_\_

Any periods of separation:  Yes  No

Domestic violence past or present?  Yes  No If yes, explain: \_\_\_\_\_

Strengths in Marriage: \_\_\_\_\_

\_\_\_\_\_

Weaknesses in Marriage: \_\_\_\_\_

\_\_\_\_\_

**Previous Marriages:**

Husband:  Yes  No Number of previous marriages: \_\_\_\_\_ Number of children from previous marriage: \_\_\_\_\_

Reasons for marriage(s) ending: \_\_\_\_\_

Wife:  Yes  No Number of previous marriages: \_\_\_\_\_ Number of children from previous marriage: \_\_\_\_\_

Reasons for marriage(s) ending: \_\_\_\_\_

**Values and beliefs of your family:** *(What's important to your family?)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Cultural Experiences and Values:** *(Discuss any experiences with different cultures, discrimination, and prejudices during childhood and adulthood.)* \_\_\_\_\_

\_\_\_\_\_

Are you willing to help preserve your guest's culture and heritage?  Yes  No If no, please explain why: \_\_\_\_\_

\_\_\_\_\_

**Religion/Spiritual Beliefs:**

Which of the following does your family participate in?

- Regular Church Attendance    Name/Location of Church \_\_\_\_\_
- Home Bible Study     Church Bible Study     Service/Mission Activities     Other: \_\_\_\_\_

**Employment:**

**Applicant 1:** \_\_\_\_\_

Current/Last Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Previous Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
 Reasons for leaving: \_\_\_\_\_

Previous Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
 Reasons for leaving: \_\_\_\_\_

**Applicant 2:** \_\_\_\_\_

Current/Last Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_

Previous Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
 Reasons for leaving: \_\_\_\_\_

Previous Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
 Title: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_ to \_\_\_\_\_  
 Reasons for leaving: \_\_\_\_\_

**Other Issues:**

**Applicant 1:** \_\_\_\_\_

- Have you ever been convicted of child abuse?     Yes     No
- Have you ever been arrested?     Yes     No
- Have you ever been convicted of a felony?     Yes     No
- Have you ever been involved in a domestic violence incident?     Yes     No
- Have you ever had a substance abuse or alcohol problem?     Yes     No
- Have you ever had mental health problems?     Yes     No
- Do you have health problems that impact your care giving role?     Yes     No
- Do you smoke?     Yes     No

If you said yes to any of the above questions, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Applicant 2:** \_\_\_\_\_

- Have you ever been convicted of child abuse?     Yes     No  
Have you ever been arrested?     Yes     No  
Have you ever been convicted of a felony?     Yes     No  
Have you ever been involved in a domestic violence incident?     Yes     No  
Have you ever had a substance abuse or alcohol problem?     Yes     No  
Have you ever had mental health problems?     Yes     No  
Do you have health problems that impact your care giving role?     Yes     No  
Do you smoke?     Yes     No

If you said yes to any of the above questions, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Support System: Contact with Family, Friends, and Neighbors (Frequency):**

- Extended Family:     Daily     Weekly     Monthly  
Neighbors:     Daily     Weekly     Monthly  
Your Church Members:     Daily     Weekly     Monthly

Who can help with childcare? (List all) \_\_\_\_\_  
If you had a crisis, who would you call? (List all) \_\_\_\_\_

**Neighborhood and Community Resources:**

What resources are in your community?     Parks     Library     Hospital     Recreational Activities

Please briefly describe your neighborhood (e.g. safety, support): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHILDREN:**

	Names	Age	School	Grade	Gender	Personalities, ect...
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

Sibling relationships:     Excellent     Good     Fair     Poor, please explain: \_\_\_\_\_  
\_\_\_\_\_

Health of Children:     Excellent     Good     Fair     Poor, please explain: \_\_\_\_\_  
\_\_\_\_\_

Behavior of Children:     Excellent     Good     Fair     Poor, please explain: \_\_\_\_\_  
\_\_\_\_\_

Discipline:     Time-Outs     Spanking     Loss of privileges     Grounding     Other: \_\_\_\_\_

Special Needs of Children:     Learning     Development     Health     Mental Health     Substance Abuse  
Explain all special needs indicated: \_\_\_\_\_  
\_\_\_\_\_

Explain children's view of having a Safe Family guest in your home: \_\_\_\_\_

\_\_\_\_\_

Do you have children living outside of your home? If yes, list names and where they live: \_\_\_\_\_

\_\_\_\_\_

**Support of Birth Parents:**

Are you interested in developing a relationship with the parent of the child in your care?  Yes  No, please explain:

\_\_\_\_\_

Do you have an age or gender, and how many children are you interested in having in your home? \_\_\_\_\_

\_\_\_\_\_

**MOTIVATION:** (Discuss reasons for wanting to become part of the Safe Family Program and Host children in your home)

\_\_\_\_\_

\_\_\_\_\_

**REFERENCES:**

Name	Address	Email	Phone
Pastor: _____	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

**RELATIVES:** (List two relatives closest to your family)

Name	Address	Email	Phone
Relative: _____	_____	_____	_____
Relative: _____	_____	_____	_____

**FINANCES:** (See \* below)

SFFC must verify that a perspective Host Family does have extra income to provide for the basic needs of a child in need, such as food, clothing, shelter, transportation, etc. Although Host Families are supplemental care and not substitute care, and parents are expected to continue to meet their child's needs, there will be some added expenses for hosting a child. The local SFFC implementing site, along with your SFFC Church ministry will also help connect Host Families to resources in the community for certain needs; however when resources are not available, it is expected for Host Families to meet those needs.

Please give your most accurate estimate of the following information:

**Applicant 1:** Monthly Income (after withholding) \$ \_\_\_\_\_ (\*optional)

**Applicant 2:** Monthly Income (after withholding) \$ \_\_\_\_\_ (\*optional)

Total Income (after withholding) \$ \_\_\_\_\_ (\*optional)

( - ) Total Monthly Payments and Expenses \$ \_\_\_\_\_ (\*optional)  
(Including food, gas, clothing, entertainment...)

( = ) Available Surplus: \$ \_\_\_\_\_ (\*required)

\* Applicant's monthly income and Payments/Expenses are optional; however the calculated available surplus amount is required.

I/We understand that by filling out this application, there is no definite commitment by me/us or by SFFC. I/We verify that the above information is true to the best of my/our knowledge and that I/we personally filled out this application myself/ourselves. I/We give SFFC permission to check my/our references and verify my/our employments.

Applicant 1: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

Applicant 1: \_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

When completed, please return application to the SFFC Local Implementation Site:

Twin Cedars Youth and Family Services  
Candi Gibson, SFFC Coordinator  
701 Lincoln Street  
LaGrange, GA 30241

(Or give to your SFFC Church Ministry Lead or Family Coach to return to us.)

Thank you for your interest in partnering in ministry with SFFC. We look forward to working with you.

For more information, please contact us at (706) 298-0050 ext. 1073 or by email at [cgibson@twincedars.org](mailto:cgibson@twincedars.org)