

**INTERNATIONAL HOMESTUDY UPDATE
DOCUMENT CHECKLIST**

I. Please complete the following document and return with your payment within 30 days:

- _____ 1. Complete JFS O1331 and return immediately with payment for Homestudy Update.
- _____ 2. Copy of previous Homestudy (unless completed by Adoption Circle).
- _____ 3. Adoption Circle Application
- _____ 4. Ohio Dept. of Human Services JFS01691 "Application for Child Placement"

II. Please complete the following documents and submit them directly to your social worker at time of visit:


- _____ 1. The JFS 01681 "Applicant Financial Statement"
- _____ 2. JFS 01653 "Medical Statement for Adoptive Parent and All Household Members" A licensed physician **MUST** complete and sign and date the entire 2nd page of this form, including professional opinion section.
- N/A 3. *Child Abuse Registry Report-**Adoption Circle will submit**
- _____ 4. *Bureau of Motor Vehicles Driving Abstract. You may secure a copy of your driving records by completing the enclosed form with \$8.50 per request. (This should be mailed to you.) Mail to:

OHIO BMV
Attn: Records Request
P.O. Box 16520
Columbus, OH 43216-6520

*** If you have not resided in Ohio for the past 5yrs., you must secure Driving Abstracts and State Child Abuse Clearances from previous state(s) of residence if not provided to Adoption Circle previously.**

- _____ 5. State Criminal and Federal Bureau of Identification (BCI & FBI) Checks: Contact National Background Check, Inc., at 1-877-932-2435 or visit www.fastfingerprints.com and follow their instructions to complete the background checks This will be forwarded to Adoption Circle. (Office locations enclosed)

- _____ 6. If employment has changed, a letter from your employer(s) stating job title, length of employment, performance, security, and income. If self-employed, please have your accountant provide a letter.
- _____ 7. A minimum of one professional or personal reference who is knowledgeable of the perspective adoptive parent(s) family's dynamics / functioning.
- _____ 8. Verification of current infant CPR certification.
- _____ 9. JFS O1200-Fire Inspection Report (see enclosed instructions). Not needed if living in the same home.
- _____ 10. Updated water test completed by approved state water testing lab if you have Well water and it is consumed for drinking or cooking.
- _____ 11. JFS 01348-Safety Audit (not needed if living in same home).
- _____ 12. Medical/Psychological Release Form.

Adoption  *Circle*
A Non-Profit, State-Licensed Agency

Date: _____

Homestudy Update Fee:

\$750.00

Total Due:

\$750.00

Balance due prior to initiation of services. Please include invoice and make checks payable to ADOPTION CIRCLE. Thank you.

How did you hear about ADOPTION CIRCLE? _____

Have you ever had an open case with Children Services? YES _____ NO _____

County _____ Year _____

Have you had a Homestudy conducted? If yes, please provide the agency, court or social worker/assessor's name, address and telephone number:

If you have an adopted child living in your home, what is their name _____, date of birth _____, date of placement _____ and date of finalization _____.

Was your child adopted through an adoption agency? _____ yes or _____ no
If yes, please provide the agency name, address and telephone number.

*Please note: Adoption Circle is required to contact the agency, court and/or social worker for a reference.

Please check the program(s) to which you are applying:

- Infant Adoption Program
- Targeted / Identified Adoption Program
- International Adoption Program
- Auxiliary Service Program

We appreciate your interest in ADOPTION CIRCLE. If you are applying to the Domestic Infant Adoption Program please return your completed Agency Application with the **NON-REFUNDABLE** \$250.00 application fee. If you are applying to any other program, there is no application fee. In order to assure our receipt of your application, you may wish to send it certified mail. Infant Adoption applicants will be receiving an invitation to the next Orientation & Education Meeting upon our receipt of your application to initiate the adoption and homestudy process. Pursuant to the Ohio Revised Code 3107.10, your County Children's Services shall be notified of your adoption homestudy and potential placement. Adoption Circle will also request a Child Abuse Registry Check upon receipt of this application. Your signed application verifies your informed consent of the release of this information to the appropriate County Children's Services and ODJFS Child Abuse Registry.

Adoptive Applicant

Date

Adoptive Applicant

Date

One Americana, Suite 304, 400 South 5th Street, Columbus, Ohio 43215 Office 614-237-7222 Fax 614-237-8484
Birthparent Helpline 1-800-927-7222 info@adoptioncircle.org www.adoptioncircle.org

Ohio Department of Job and Family Services
APPLICATION FOR CHILD PLACEMENT

AGENCY USE ONLY			
Assessor Name	Agency Name	Agency Phone #	Date Completed Application Received

Applicant #1 Name <i>(Please Print)</i>				Applying to	Pager or Cell Phone #	
First	Middle	Last	(Maiden)	<input type="checkbox"/> Foster	Work Phone #	
				<input type="checkbox"/> Adopt	Work Fax #	
Applicant #2 Name <i>(Please Print)</i>				Applying to	Pager or Cell Phone #	
First	Middle	Last	(Maiden)	<input type="checkbox"/> Foster	Work Phone #	
				<input type="checkbox"/> Adopt	Work Fax #	
Street Name & Address (Apt. or Lot #)			City	State	Zip Code	County
Home Telephone Number		Home Fax Number		Emergency Contact Name		Telephone Number

HOUSEHOLD MEMBERS (If more than 6 people, add another sheet)

Name	Applicant #1	Applicant #2	Household Member	Household Member	Household Member	Household Member
Relationship to Applicant #1						
Date of Birth						
Race*						
Ethnic Background*						
School Grade Completed						
Marital Status (if currently married, date of marriage)						
Area of Specialized Education if applicable						
Employer or Source of Income						
How long with this employer						
Occupation						
Gross Annual Income						
Days/Hours of Work (in normal work week)						
Driver's License Number						

* For statistical purposes only

CRIMINAL HISTORY

Does any household member, including juveniles 12 - 18 years of age, have a criminal history? Yes No If yes, explain below

Name	Offense	City and State	Approximate Conviction Date	Sentence

Has any household member been arrested/convicted for driving while intoxicated (DWI) or driving under the influence (DUI)?

Yes No If yes, explain below

Name	Number of Arrests	Number of Convictions	Date of Last Conviction	City/State of Last Conviction	On Probation or Parole?	License Suspended or Revoked?
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SLEEPING ARRANGEMENTS (Indicate where a foster or adopted child will sleep)

BEDROOM	FLOOR/LEVEL	OCCUPANT(S)	TYPE OF BED(S) Crib, Single, Double, Bunk (If bunk, indicate upper - U or lower - L)
1			
2			
3			
4			
5			
6			

Directions to home from agency

Children placed in the home would attend the following schools

Elementary School Name	Address
Middle School or Junior High School Name	Address
Senior High School Name	Address

Name of Public School District Do you plan to home school children? Yes No

If yes, indicate whether your home school plan has been approved by the public school district. Yes No

Does any family member smoke? Yes No Is smoking allowed in the house? Yes No
 Are there any pets in the home? Yes No If yes, list/describe:
 Do pets meet local safety requirements (Vaccinations, vicious animal restrictions, etc.)? Yes No

Comments

Does applicant operate a business from the residence? Yes No Explain:
 If yes, is business child care? Yes No Is business adult day care or a rooming house? Yes No

Describe impact of home business on foster care/adoption plan:

TRANSPORTATION

VEHICLES One car Two or more cars Truck Van Recreational Vehicle Motorcycle Other

Are vehicles in operable condition? Yes No If no, explain

Are there infant car seats? Yes No Will Obtain

Are there toddler car seats? Yes No Will Obtain

Do you have proof of insurance for all vehicles? Yes No

Is the home on or within comfortable walking distance of public transportation system (bus, etc.)? Yes No

If yes, distance to nearest transit or bus stop

Describe alternative transportation plan if family does not own an operating vehicle or live on or within comfortable walking distance of a bus stop

APPLICANT, RESIDENTIAL, EMPLOYMENT AND MARITAL HISTORY (Add extra sheets if necessary)

Residential History List residences for the last 10 years	Applicant #1		Applicant #2	
Has the applicant been an Ohio resident for the last five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency use only. How verified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency use only. How verified?
Date moved to current residence				
Previous address (city, state)				
Date moved to this address				
Previous address (city, state)				
Date moved to this address				
Previous address (city, state)				
Date moved to this address				

Employment History Last applicant's employer(s) for the last 10 years:		Applicant #1	Applicant #2
Present employer Job title Length of time with present employer			
Previous employer Job title Dates of employment			
Previous employer Job title Dates of employment			
Previous employer Job title Dates of employment			
Marriage/Relationship History		Applicant #1	Applicant #2
Previous marriage/significant relationship to Date marriage or relationship began Date of separation Date of legal termination			
Previous marriage/significant relationship to Date marriage or relationship began Date of separation Date of legal termination			
TYPE OF CHILD WILL CONSIDER			
Please tell us what type of child you are interested in fostering or adopting. Check all that apply. If you are applying to foster or adopt a specific child(ren), put his/her name(s) here			
Is this child related to you by blood or marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No If applicable, specify relationship			
Age 0 - 2 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider 3 - 5 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider 6 - 8 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider 9 - 11 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider 12 - 15 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider 16 - 18 <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider		Race White <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Black/African American <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Asian <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider American Indian or Alaskan Native <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider	
Number of Children One <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Two <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Three or more <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Teen Parent w/ Child <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider		Ethnicity: Hispanic or Latino <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Not Hispanic or Latino <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider	
Sex Male <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider Female <input type="checkbox"/> Will Consider <input type="checkbox"/> Will Not Consider		Applicant(s) Comments	

EXPERIENCE WITH CHILDREN

Have you ever been or are you currently certified as a foster caregiver in this state or any other state? Yes No
 Have you ever applied for or been approved to adopt a child in this state or any other state? Yes No

If you answered yes to either of these questions, explain here, and identify the agency involved

Some people have had previous contact with a child welfare agency. Sometimes this is a positive experience, sometimes not so positive. Please tell us about any contact either applicant has had with a child welfare agency (Children Services, Child mental health facility, community child serving agencies, etc.). Please give the name of the agency, approximate dates of contact and what the contact involved. Include both positive and negative experiences.

Check here if you have no experience with child welfare agencies

Describe your experience with children other than your own. This may include employment and/or volunteer work.

References

The state requires three non-relative references for foster care, three non-relative references for adoption, and three non-relative references for a combined foster care/adoption study. Some agencies or local court systems require additional references. If the agency has filled in the blanks below, it or the court has requirements beyond the state rule. If the blanks below contain a number, you will need to supply that number of references. If the spaces are empty, please supply three non-relative references for foster care and four (three from non-relatives) for adoption.

of references for foster care # of references for adoption OR # of references for a combined foster care/adoption study

Reference Name	Relationship	Phone Number	Street Address	City	State	Zip Code

May we contact your employer for a reference? Applicant #1 Yes No Applicant #2 Yes No

If this box has an X in it your local agency or court *requires* an employer reference. Your application cannot proceed without permission to obtain this reference. Please provide the following information

	Supervisor's Name	Phone Number	Employer Address	City	State	Zip Code
Applicant #1						
Applicant #2						

STATEMENT OF UNDERSTANDING

I/we understand that this is an application only and additional documents will be required. This will include medical statements, criminal background check, homestudy, safety audit of your home, references, and other information or documentation requested by the agency. Failure of an applicant to provide required information or documentation or to attend required training within one year from the date the completed application is received by the agency will render this application incomplete and the agency's file on the application will be closed.

I/we agree to complete orientation and preplacement training as required by the agency.

This application does not represent a final commitment on either side. Any placement of a child will be by my/our mutual agreement.

I/we certify that the information contained in this application is accurate and complete to the best of my knowledge.

I/we understand that providing materially false information will prevent the agency from considering my/our home for placement of a child and is grounds for denial or revocation of a foster home certificate.

If there is any significant change affecting health, marital status, residence, family composition or household occupants, employment or criminal charges, I/we agree to notify the agency promptly.

I/we give permission to the agency to contact any references or agency or association for information regarding any work or involvement with the supervision of a child which I/we have done.

I/we certify that I/we have been given a copy of the rules and/or policies governing the certification of foster homes (Chapters 5101:2-5 and 5101:2-7 of the Administrative Code), if I/we are applying to be a foster caregiver.

I/we certify that I/we have been given a copy of the PCSA, PCPA or PNA adoption policy, or summary of the policy, prepared pursuant to rule 5101:2-48-05 of the Administrative Code, if I/we are applying to become an adoptive parent.

Applications for a foster home certificate cannot be accepted by agents of the Ohio Department of Job and Family Services for a residence that is licensed, regulated, operated under the direction of or otherwise certified as a facility to care for unrelated persons, by the Ohio Department of Education, a local board of education, the Ohio Department of Mental Health, a community alcohol, drug addiction and mental health services board, the Ohio Department of Mental Retardation/ Developmental Disabilities, a county board of mental retardation/developmental disabilities, the Ohio Department of Health or a juvenile court.

A person seeking to provide foster care or to adopt a minor who knowingly makes a false statement that is included in the written report of a home study conducted pursuant Section 3107.02 or Section 5103.03 of the Revised Code is guilty of the offense of falsification under Section 2921.13 of the Revised Code. A home study with a knowingly false statement shall not be filed with the court and if filed may be struck from the court's records.

Applicant Name <i>(please print)</i>	Signature	Date
Applicant #1		
Applicant #2		

Please tell us how you were referred to this agency.

Note: Completion of this form is required in order for this agency to carry out its obligations under Chapters 5101:2-5, 5101:2-7, and/or 5101:2-48 of the Ohio Administrative Code. Your application cannot be processed unless this form is completed in its entirety.

NOTICE OF EXPIRATION AND REAPPLICATION FOR A FOSTER HOME CERTIFICATE OR ADOPTION HOMESTUDY UPDATE/AMENDMENT

SECTION I: (Complete foster caregiver information for foster home certification and/or adoptive parent information for adoption homestudy update/amendment).		
First and Last Name of Foster Caregiver or Adoptive Parent #1	First and Last Name of Foster Caregiver or Adoptive Parent #2	
Street Address	Apt. #	Lot #
City	State	Zip
1A.	The purpose of this form is to let you know that your <input type="checkbox"/> certificate as a foster home and/or <input checked="" type="checkbox"/> adoption homestudy is scheduled to expire on <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Foster Home Certification Update due Adoption Homestudy Update due </div>	
1B.	If you wish to continue as a foster home and/or adoptive home, please check box 2A and/or 2B of Section II below, sign and date the form at the bottom and return the form to me by . Also, provide any information required to be submitted as indicated in 1G below.	
1C.	If you indicate you want to be recertified as a foster home, a representative of the agency will contact you in order that we may update our records and make a recommendation to the Ohio Department of Job and Family Services regarding the continuation of your foster home certification.	
1D.	If you indicate you want to remain approved as an adoptive home, a representative of the agency will contact you once this completed form has been returned.	
1E.	If you no longer wish to be certified as a foster home and/or approved as an adoptive home, please check box 2C and/or 2D of Section II below, include the effective date of termination, sign the form at the bottom and return to me by	
1F.	If you do not return this form to the agency, your certificate as a family foster home and/or your approval as an adoptive home will automatically expire on the date listed above in paragraph 1A.	
1G.	Additional information or documentation required to be submitted for recertification or approval.	
1H.	Form mailed to <input type="checkbox"/> Foster caregiver(s) <input checked="" type="checkbox"/> Adoptive parent(s) Date	
Name of Agency Representative		Signature of Agency Representative
SECTION II: (Please check the appropriate box below, sign, date and return to the agency. If you check 2C and/or 2D, please insert the date you are requesting your foster home certificate and/or approval as an adoption home be terminated.		
2A.	<input type="checkbox"/> I/we wish to continue to be certified as a foster home under Chapter 5101:2-7 of the Ohio Administrative Code.	
2B.	<input type="checkbox"/> I/we wish to continue to be approved as an adoptive home under Chapter 5101:2-48 of the Ohio Administrative Code.	
2C.	<input type="checkbox"/> I do not wish to continue to be certified as a foster home under Chapter 5101:2-7 of the Ohio Administrative Code. I am requesting my certificate be terminated effective: (not to extend beyond the expiration date of the current certificate).	
2D.	<input type="checkbox"/> I do not wish to continue to be approved as an adoptive home under Chapter 5101:2-48 of the Ohio Administrative Code. I am requesting my homestudy be terminated effective: (not to extend beyond the expiration date of the current approval).	
Signature of Foster Caregiver or Adoptive Parent #1		Date
Signature of Foster Caregiver or Adoptive Parent #2		Date

Use of this form is mandated by OAC chapters 5101:2-5 and 5101:2-48. Failure to use this form may be cause to deny certification or licensure.

Ohio Department of Job and Family Services

APPLICANT FINANCIAL STATEMENT

Name (Last, First, Middle)	Number of Dependent Adults (Include Self)	Number of Dependent Children
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The following information is being asked to assist you and the agency in your child placement planning. Please complete the financial statement using estimated monthly amounts.

A. MONTHLY INCOME

1. Family Member _____	Gross pay per month \$ _____	Net pay per month	\$ _____
2. Family Member _____	Gross pay per month \$ _____	Net pay per month	\$ _____
3. Other income (real estate, adoption subsidy, retirement, child support, public assistance, social security, etc.)			\$ _____
			\$ _____
			\$ _____
			\$ _____
TOTAL NET MONTHLY INCOME			\$ 0.00

B. MONTHLY EXPENDITURES

1. Rent or mortgage (including taxes and insurance)	\$ _____	
2. Utilities (including telephone)	\$ _____	
3. Other fixed expenses	\$ _____	
a. Child Care	\$ _____	
b. Car payments	\$ _____	
c. Credit card payments	\$ _____	
d. Other loan payments	\$ _____	
e. Child support or alimony	\$ _____	
f. Regular savings/investments	\$ _____	
g. Other (Specify)	\$ _____	
TOTAL MONTHLY EXPENDITURES		\$ 0.00

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION FOR A CHILD.

C. ASSETS

	TOTAL VALUE
1. Residence Market value	\$
2. Other real estate Market value	\$
3. Cars - Specify	\$
_____	\$
_____	\$
4. Savings	\$
5. Stocks/Bonds	\$
6. Other assets - Specify	\$
TOTAL ASSETS	\$ 0.00

D. LIABILITIES

	BALANCE OWED
1. Residence mortgage	\$
2. Other mortgage	\$
3. Cars loans	\$
4. Other loans	\$
5. Credit cards	\$
6. Other	\$
TOTAL LIABILITIES	\$ 0.00

E. INSURANCE COVERAGE

	Total Coverage Amount	Monthly Cost to Applicant	Company
Life Insurance			
Applicant _____	\$	\$	
Applicant _____	\$	\$	
Children _____	\$	\$	
Medical Insurance	\$	\$	
Automobile Insurance	\$	\$	
Other	\$	\$	

F. ANY PERTINENT INFORMATION NOT COVERED

Applicant Signature	Date
---------------------	------

Applicant Signature	Date
---------------------	------

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT
 AND ALL HOUSEHOLD MEMBERS**

Name (Last, First, Middle)	Date of Birth
Address (Street, City, State and Zip)	

1. Have you had treatment for a serious or chronic illness? Yes No
- Have you been hospitalized in the past five years? Yes No
- Have you ever received, or been advised to seek, mental health services? Yes No
- Have you ever received, or been advised to seek, treatment for Alcohol/substance abuse? Yes No

If any are checked, please explain: _____

2. Have you or your parents, grandparents, or siblings had any of the following? (Check all that apply and indicate whom)

- | | |
|--|--|
| <input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ulcers _____ |
|--|--|

If any are checked, please explain: _____

3. Is there a history of other hereditary disease? Yes No

If yes, please explain: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:

 (Name of Agency)

Signature of Applicant

Date

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION

Date you last completed a physical examination of this individual	Date you last treated this individual
Do you provide services to this individual	
<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> First Time	

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home? Yes No
2. Are there any chronic or serious disorders for which this individual has received treatment? Yes No
3. Is this individual currently taking medication? Yes No
4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home? Yes No
5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? Yes No

If the answer to any of the above questions is YES, please explain: _____

(For foster/adoptive applicant only, please complete)

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual. _____

Signature	Date	Name (<i>Print or Type</i>)	
Please check one of the following		Work Address	
<input type="checkbox"/> Licensed Physician	<input type="checkbox"/> Physician Assistant	Work Phone Number	
<input type="checkbox"/> Clinical Nurse Specialist	<input type="checkbox"/> Certified Nurse Practitioner	State License Number	
<input type="checkbox"/> Certified Nurse-Midwife			

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules 5101:2-5-20 or 5101:2-48-07.

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT
 AND ALL HOUSEHOLD MEMBERS**

Name (<i>Last, First, Middle</i>)	Date of Birth
Address (<i>Street, City, State and Zip</i>)	

1. Have you had treatment for a serious or chronic illness? Yes No
- Have you been hospitalized in the past five years? Yes No
- Have you ever received, or been advised to seek, mental health services? Yes No
- Have you ever received, or been advised to seek, treatment for Alcohol/substance abuse? Yes No

If any are checked, please explain: _____

2. Have you or your parents, grandparents, or siblings had any of the following? (*Check all that apply and indicate whom*)

- | | |
|--|--|
| <input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ulcers _____ |
|--|--|

If any are checked, please explain: _____

3. Is there a history of other hereditary disease? Yes No

If yes, please explain: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:

(Name of Agency)

Signature of Applicant

Date

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION

Date you last completed a physical examination of this individual	Date you last treated this individual
Do you provide services to this individual	
<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasionally
<input type="checkbox"/> First Time	

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home? Yes No
2. Are there any chronic or serious disorders for which this individual has received treatment? Yes No
3. Is this individual currently taking medication? Yes No
4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home? Yes No
5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? Yes No

If the answer to any of the above questions is YES, please explain: _____

(For foster/adoptive applicant only, please complete)

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual. _____

Signature	Date	Name (Print or Type)	
Please check one of the following		Work Address	
<input type="checkbox"/> Licensed Physician	<input type="checkbox"/> Physician Assistant		
<input type="checkbox"/> Clinical Nurse Specialist	<input type="checkbox"/> Certified Nurse Practitioner	Work Phone Number	State License Number
<input type="checkbox"/> Certified Nurse-Midwife			

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules 5101:2-5-20 or 5101:2-48-07.

Ohio Department of Job and Family Services
**MEDICAL STATEMENT FOR FOSTER CAREGIVER/ADOPTIVE APPLICANT
 AND ALL HOUSEHOLD MEMBERS**

Name (<i>Last, First, Middle</i>)	Date of Birth
Address (<i>Street, City, State and Zip</i>)	

1. Have you had treatment for a serious or chronic illness? Yes No
- Have you been hospitalized in the past five years? Yes No
- Have you ever received, or been advised to seek, mental health services? Yes No
- Have you ever received, or been advised to seek, treatment for Alcohol/substance abuse? Yes No

If any are checked, please explain: _____

2. Have you or your parents, grandparents, or siblings had any of the following? (*Check all that apply and indicate whom*)

- | | |
|--|--|
| <input type="checkbox"/> Arthritis _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Ulcers _____ |
|--|--|

If any are checked, please explain: _____

3. Is there a history of other hereditary disease? Yes No

If yes, please explain: _____

AUTHORIZATION FOR RELEASE OF INFORMATION	
I hereby affirm that I have completed this form to the best of my ability, and that the information provided is true and correct. I further authorize the physician completing the reverse side of this form to release any information he/she may have concerning my physical or mental health to:	
_____ <i>(Name of Agency)</i>	
Signature of Applicant	Date

COMPLETION OF THIS FORM IS REQUIRED FOR THE AGENCY TO PROCEED WITH YOUR APPLICATION

Date you last completed a physical examination of this individual	Date you last treated this individual
Do you provide services to this individual	
<input type="checkbox"/> Regularly	<input type="checkbox"/> Occasionally
<input type="checkbox"/> First Time	

Please respond to each of the following to the best of your knowledge:

1. Does this individual suffer from an illness, including a communicable disease, that would be detrimental to the care of a foster/adoptive child placed in his/her home? Yes No
2. Are there any chronic or serious disorders for which this individual has received treatment? Yes No
3. Is this individual currently taking medication? Yes No
4. Is this individual experiencing any physical, behavioral or emotional problems that would be detrimental to a foster/adoptive child placed in his/her home? Yes No
5. Have you ever referred this individual to other medical services, mental health services or treatment for alcohol/substance abuse? Yes No

If the answer to any of the above questions is YES, please explain: _____

(For foster/adoptive applicant only, please complete)

Please state your professional opinion regarding this individual's suitability as a foster/adoptive parent from the standpoint of health, considering the individual's medical history as given on the reverse side of this form and from knowledge you have of the individual. _____

Signature	Date	Name (Print or Type)	
Please check one of the following		Work Address	
<input type="checkbox"/> Licensed Physician	<input type="checkbox"/> Physician Assistant		
<input type="checkbox"/> Clinical Nurse Specialist	<input type="checkbox"/> Certified Nurse Practitioner		
<input type="checkbox"/> Certified Nurse-Midwife			
		Work Phone Number	State License Number

NOTE: Completion of this form is required pursuant to Ohio Administrative Code Rules 5101:2-5-20 or 5101:2-48-07.



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

OBMV RECORD REQUEST

(Ohio Revised Code [O.R.C.] 149.43, 4501.15, 4501.27, AND 4507.53)

This agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under O.R.C. 4501.27. Disclosure of this information is **REQUIRED**. **FAILURE** to provide any information will result in this form not being processed.

▶ **This request is being made by (check one):**

- An individual inquiring regarding himself or herself:** (Complete **Part A**) If inquiring in person for information on yourself, you must provide personal information regarding yourself, or prove your identity by presenting your driver license or identification card.
- An individual inquiring regarding another person:** (Complete **Parts A and B**) If inquiring regarding another individual, you must attach a notarized BMV Form 5008 giving the written consent of the person. All mail requests without the BMV Form 5008 attached will be returned to the requester.
- Other:** (Check applicable reason for request on **Part C**, and complete **Parts A and B**)

▶ **I am requesting the following personal information contained in the Bureau of Motor Vehicles records:**

<input checked="" type="checkbox"/> Driving Record [302] (\$8.50)	<input type="checkbox"/> Title Owner/Lien holder information [304] (\$2.00)
<input type="checkbox"/> Vehicle Registration Record [303] (\$8.50)	<input type="checkbox"/> Certified Owner/Lien holder information [304A] (\$4.00)
<input type="checkbox"/> Last Known Address [405] (\$8.50)	
<input type="checkbox"/> Copy of Driver License Application [405A] (\$8.50)	

NOTE: There is a \$3.50 processing fee included in the above listed record requests.

PART A: Please provide current information regarding yourself:		NOTE: SIGNATURE REQUIRED	
YOUR NAME (REQUESTER)	DATE OF BIRTH	SIGNATURE X	
CURRENT STREET ADDRESS	CITY	STATE	DATE
COMPANY (IF APPLICABLE)	BMV ACCOUNT # (IF APPLICABLE)		
SOCIAL SECURITY #	DRIVER LICENSE #	LICENSE PLATE #	
VEHICLE IDENTIFICATION #	TITLE #	TELEPHONE #/FAX #	

PART B: Request regarding other person(s)			
PERSON'S NAME		DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY #	DRIVER LICENSE #	LICENSE PLATE #	
VEHICLE IDENTIFICATION #	TITLE #		

If requesting information on more than 1 person or vehicle, attach additional sheet(s).

Additional sheet(s) attached

Make check or money order payable to **Ohio Treasurer Kevin L. Boyce**. If mailing, return to: **Ohio Bureau of Motor Vehicles, Attn: Records Request, P.O. Box 16520, Columbus, Ohio 43216-6520. Results will be mailed to requester.**



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

OBMV RECORD REQUEST

(Ohio Revised Code [O.R.C.] 149.43, 4501.15, 4501.27, AND 4507.53)

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<input type="checkbox"/> Copy of Driver License Application [405A] (\$8.50)	

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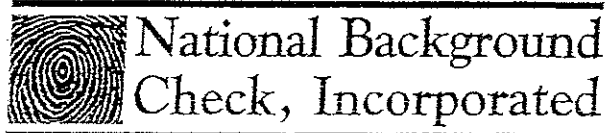
PART A: Please provide current information regarding yourself:		NOTE: SIGNATURE REQUIRED	
YOUR NAME (REQUESTER)	DATE OF BIRTH	SIGNATURE X	
CURRENT STREET ADDRESS	CITY	STATE	ZIP
COMPANY (IF APPLICABLE)	BMV ACCOUNT # (IF APPLICABLE)		
SOCIAL SECURITY #	DRIVER LICENSE #	LICENSE PLATE #	
VEHICLE IDENTIFICATION #	TITLE #	TELEPHONE #/FAX #	

PART B: Request regarding other person(s)			
PERSON'S NAME		DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY #	DRIVER LICENSE #	LICENSE PLATE #	
VEHICLE IDENTIFICATION #	TITLE #		

If requesting information on more than 1 person or vehicle, attach additional sheet(s).

Additional sheet(s) attached

Make check or money order payable to **Ohio Treasurer Kevin L. Boyce**. If mailing, return to: **Ohio Bureau of Motor Vehicles, Attn: Records Request, P.O. Box 16520, Columbus, Ohio 43216-6520. Results will be mailed to requester.**



National Background Check, Inc. (NBCI)

ELECTRONIC FINGERPRINTING

FastFingerprints offers an enhanced Webcheck System known as National Webcheck (NWC) to capture and submit fingerprint data to the Ohio Bureau of Criminal Identification & Investigation (BCI) and the Federal Bureau of Investigation (FBI).

Because the FastFingerprints process for fingerprinting uses state-of-the-art scanners and secure submission procedures, the process is virtually error-free, avoiding smudged readings and/or delivery errors often associated with the ink processing method.

Frequently Asked Questions

Q: How do I schedule an appointment to be fingerprinted?

A: Schedule online by clicking on our SCHEDULE tab on the website www.fastfingerprints.com or call 1-877-932-2435 toll free.

Q: Can I just send in the fingerprint card I got from the police station?

A: No. We actually scan your fingerprint using a fingerprint camera. The only way to do it is to actually put your finger on the scanner.

Q: How long does it take?

A: It only takes about two minutes to scan your prints. We also ask that you fill out a registration form. This form tells us where to send the results once we receive them. This should only take a few minutes. You can literally be in and out of our office in ten minutes.

Q: What do I need to bring with me?

A: You will need a valid government issued picture I.D. as well as cash, check or credit card (Visa, MC or AMEX). Please bring the address of where you would like the results sent. If your company is paying for you, make sure to bring the receipt showing that it's paid or the Direct Bill Registration Form showing which company we need to bill. You will also need to know reason/purpose for fingerprinting. We also suggest that you use moisturizer prior to coming to our faculty. Dry fingers can be difficult to print.

Q: What types of identification do you accept?

A: Driver's license, State I.D. card, Passport, Military I.D. or Green Card. Must be valid and no copies.

Q: How long will it take until my results reach the appropriate agency I indicated on the registration form?

A: We typically receive the results in a matter of hours. They are sent out the following day via secure email or U.S. Mail. It should only be two or three days until the agency receives your results. If there was a criminal arrest in your past, we are notified within two days that your results are being mailed from BCI&I. BCI&I takes anywhere from 3-10 days to process the mailed results. We will then mail them off to the agency requesting the background check.

Please contact us for additional information

(877) 932-2435 or info@FastFingerprints.com

www.FastFingerprints.com

LOCATIONS:

Akron / Canton

1505 Corporate Woods Parkway Suite 100 - HONDROS COLLEGE
Uniontown, OH 44685

Special Notes:

Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS.
Hours: Monday-Friday (8:00 am - 5:00 pm)

Cincinnati

4605 Duke Drive, Suite 115 (inside HONDROS COLLEGE)
Mason, OH 45040

Special Notes:

Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS.
Hours: Monday-Friday (8:00 am-5:00 pm) and Saturdays (9:00 am-12:00 pm).

Cincinnati-West Chester

7600 Tylers Place Blvd. (inside HONDROS COLLEGE)
West Chester, OH 45069

Special Notes:

Located inside the Hondros College School of Nursing. Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS.

Cleveland South

4100 Rockside Road (Inside HONDROS COLLEGE/IWU)
Independence, OH 44131

Special Notes:

*** Cleveland South Construction Notice *** From I77, head westbound on Rockside Rd. Turn left onto Oak Tree Blvd South. At the 1st drive on the right side of the street, turn right (There will be a white sign that says Indiana Wesleyan University & VFW). Follow the drive in the parking lot until you see a smaller white sign on the right side with our address of "4100". Turn right, this is our parking lot. NBCI is located in Hondros College on the 2nd Floor. Expect construction delays and please allow extra driving time. (Please note that the signs posted do not have Hondros College's name on them. It refers to Indiana Wesleyan University.) 2nd Floor Indiana Wesleyan University Building Hours: Monday-Friday (8:00 am-5:00 pm) and Saturdays (9:00 am-12:00 pm).

Columbus

1486 Bethel Road (in Bethel Centre)
Columbus, OH 43220

Special Notes:

Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS.
Hours: Monday-Friday (8:00 am-5:00 pm) and Saturdays (9:00 am-12:00 pm).
WALK-INS WELCOME!

Dayton

1810 Successful Drive (Inside HONDROS COLLEGE)
Fairborn, OH 45324

Special Notes:

Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS.
Hours: Monday-Friday (8:00 am-5:00 p.m.)

Mobile Service

Call us for details

Anywhere, OH -

Special Notes:

Call 1-877-932-2435 ext.6291 or 614-557-1255 for details. NBCI will come to your location for large groups anywhere in Ohio. Additional travel charges apply.

Toledo

1750 Indian Wood Circle (inside HONDROS COLLEGE)

Maumee, OH 43537

Special Notes:

*This is the Therma-Tru Doors building. Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS. Hours: Monday-Friday (8:00 am-5:00 pm)

West Chester

7600 Tylers Place Blvd. (inside Hondros College)

West Chester, OH 45069

Special Notes:

Located inside the Hondros College School of Nursing. Services at this location are the OHIO BCI and/or FBI fingerprint checks. Hours: Monday-Friday (8:00 am-5:00 pm)

Westerville

4140 Executive Parkway (inside HONDROS COLLEGE)

Westerville, OH 43081

Special Notes:

Services at this location are the OHIO BCI and/FBI BACKGROUND CHECKS. Hours: Monday-Friday (8:00 am-5:00 pm) and Saturdays (9:00 am-12:00 pm).

Youngstown

19 East Front St

Atway & Cochran, LLC

Youngstown, OH 44503

Special Notes:

Services at this location are the OHIO BCI and/or FBI FINGERPRINT CHECKS. Hours of Operation, M-F, (9:00 am - 12:00 pm, 1:00 pm - 4:00 pm). NO Saturday hours are available. LIQUOR PERMITS CAN NOT BE PROCESSED AT THIS LOCATION!!!

ADOPTIVE APPLICANT REFERENCE LETTER

SECTION I

Adoptive Applicant No. 1: _____

Adoptive Applicant No. 2: _____

SECTION II

Name of Reference: _____

Address of Reference: _____

Telephone number of Reference: _____

SECTION III

The above named applicant/s has/have applied to **ADOPTION CIRCLE** in hopes of adopting a child. We would appreciate your honest answers to the following questions as a reference for this/these applicant/s. This reference should not be considered confidential as it may be sent to other individuals/agencies as part of the applicant's homestudy.

1. How long have you known the applicant/s?
2. What is your relationship to the applicant/s? (friend, physician or other profession)
3. What are your feelings and impressions of the applicants' ability to parent an adopted child?(If more space is needed please attach additional page)

Signature/date

Signature/date

Upon completion please mail the completed form to: **ADOPTION CIRCLE**

400 S. 5th St.

Suite 304

Columbus, Ohio 43215

FIRE INSPECTION REPORT

- You will need to call the Fire Department yourself to schedule an appointment for them to come out and inspect your home.
- The Fire Department will be looking for the following things when they come to your home for your inspection:
 - 1) A working smoke detector on each floor
 - 2) An approved Fire Extinguisher near cooking area
 - 3) Floor plan drawn out for escape route
 - 4) No storage within three feet of hot water tank and furnace
 - 5) Child's room must have two escape routes (i.e. a door and a window)
 - 6) No Loose wires or cords



Ohio Department of Job and Family Services
FIRE INSPECTION REPORT FOR RESIDENTIAL FACILITIES CERTIFIED BY ODJFS

FACILITY TYPE	BUILDING CODE REFERENCES	COUNTY
<input type="checkbox"/> Foster or Adoptive Home, 5 or fewer foster or adoptive children	<input type="checkbox"/> Building code applied at time of last inspection report	
<input type="checkbox"/> Group Home, up to 10 children	<input type="checkbox"/> No information available (new application)	
<input type="checkbox"/> Children's Residential Center, 11 or more children	<input type="checkbox"/> Not applicable	
Name of Family/Facility		Recommending Agency
Street Address		Street Address
City, State, Zip Code		City, State, Zip Code
Person with whom report was discussed		

This is to certify that I inspected the building(s) comprising this child care facility and find						
Type of Structure	<input type="checkbox"/> Single Family <input type="checkbox"/> Mobile <input type="checkbox"/> Modular	<input type="checkbox"/> Two Family	<input type="checkbox"/> Apartment	<input type="checkbox"/> Group Home	<input type="checkbox"/> Children's Residential Center	
Type of Construction	<input type="checkbox"/> Frame	<input type="checkbox"/> Brick	<input type="checkbox"/> Block	<input type="checkbox"/> Other (specify)		
Type of Floors	<input type="checkbox"/> Wood	<input type="checkbox"/> Concrete	<input type="checkbox"/> Other (specify)			
Type of Stairways	<input type="checkbox"/> Wood	<input type="checkbox"/> Concrete	<input type="checkbox"/> Steel	<input type="checkbox"/> Other (specify)		
Number of floors _____. What floors have been approved for sleeping arrangements?						
<input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Basement						
Explain limitations, if any, on approval for sleeping arrangements						
* A working U.L. approved smoke alarm on each level of occupancy of the home?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
* A U.L. approved portable fire extinguisher in working order in or near cooking area?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
* Are unvented kerosene heaters U.L. approved and not prohibited by local ordinance?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
** Are smoke detectors located according to instructions of the local fire inspector or state fire marshal?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
** Free standing wood burning stoves and unvented kerosene gas or oil heaters shall not be used. Is there any evidence of usage?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
** Is the written calendar of periodic fire drills (developed by the agency) approved by fire inspector?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
** Is the evacuation plan approved?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
* Foster and adoptive homes ** Group Homes or Children's Residential Centers						
Distribution for Foster and Adoptive Homes: White – Recommending Agency; Canary – Family; Pink – Fire Inspector Distribution for Group Home or Children's Residential Center – White – ODJFS Licensing; Canary – Facility; Pink – Fire Inspector						

Page 2 must be completed

If applicable, what type of fire alarm system is provided?	
Is the facility reasonably free from conditions hazardous to the safety of children and approved as such? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, list violations	
State the recommendations for correction of all violations listed above.	

All violations must be corrected. Reinspection and approval are required if any violations listed are not immediately corrected on the spot.

Date Inspected	
Inspected by (Signature)	
Title	
Name of Fire Department	Telephone Number

Date Reinspected
Reinspected and Approved By (Signature)
Title
Name of Fire Department

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
SAFETY AUDIT OF A FOSTER HOME
 Also used for adoptive homes

Identifying Information:

Name of Caregiver #1 (Last)	First	Name of Caregiver #2 (Last)	First
Street Address		City	State
			Zip Code
Name of Agency		<input type="checkbox"/> Initial Certification	<input type="checkbox"/> Recertification
		<input type="checkbox"/> Adoptive Home	<input type="checkbox"/> Relocation

1.	The home and all structures associated with the home are maintained in a clean, safe, and sanitary condition and in a reasonable state of repair. 5101:2-7-12(A)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Outdoor recreation equipment on the grounds of the home is maintained in a safe state of repair. 5101:2-7-12(B)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
3.	Potentially hazardous outdoor areas on the grounds of or immediately adjacent to the home are reasonably safeguarded. 5101:2-7-12(C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
4.	The home is adequately heated, lighted and ventilated. 5101:2-7-12(D)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Bleach, cleaning materials, other poisonous or corrosive household chemicals, flammable and combustible materials, potentially dangerous tools or utensils, and electrical equipment or machinery in or on the grounds of the home are stored in a safe manner. 5101:2-7-12(E)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Firearm, air rifles, hunting slingshot or other projectile weapons kept on the grounds of or in the home are stored in an inoperative condition in a locked area inaccessible to children. 5101:2-7-12(F)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
7.	Ammunition, arrows or projectiles for weapons are stored in a locked area separate from the weapon. 5101:2-7-12(F)	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
8.	There is reasonable access to a working telephone for emergency situations. 5101:2-7-12 (G)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Emergency telephone numbers posted: 5101:2-7-12(H) <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Squad/Rescue <input type="checkbox"/> Poison Control <input type="checkbox"/> Recommending Agency <input type="checkbox"/> Placing Agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	All locking doors to any room or storage area inside the home in which a person could become confined, and from which the only other means of exit requires the use of a key, shall be able to be unlocked from either side. 5101:2-7-12(I)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Well water used for drinking and cooking shall be tested and approved by the health department prior to initial certification of the home and annually; or there is a continuous supply of safe drinking water. 5101:2-7-12(J)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	The home has working bathroom and toilet facilities located within the home and connected to an indoor plumbing system. 5101:2-7-12(K)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Garbage shall be disposed of on a regular basis. Garbage stored outside shall be in covered containers or closed bags. 5101:2-7-12(L)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	The home has a working smoke alarm approved by "Underwriter's Laboratory" on each level of occupancy. 5101:2-7-12(M)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	The home has a written evacuation plan for evacuating the home or seeking shelter in the event of fire, tornado or other disaster. 5101:2-7-12(N)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	The evacuation plan contains a primary and alternate escape for each floor. 5101:2-7-12(N)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	All escape routes shall be kept free of clutter and other obstructions. 5101:2-7-12(O)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
SAFETY AUDIT OF A FOSTER HOME
Also used for adoptive homes**

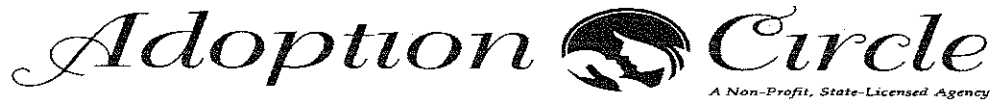
18.	Household heating equipment is equipped with appropriate safeguards in accordance with age and functioning level of foster children in the home. 5101:2-7-12(P)	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Any unvented kerosene heaters used in the home are approved by "Underwriter's Laboratory". 5101:2-7-12(Q)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
20.	The home has an "Underwriter's Laboratory" approved portable fire extinguisher in working order in or near the cooking area of the home. 5101:2-7-12(R)	<input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Pets or domestic animals in or on the premises of the home are kept in a safe and sanitary manner in accordance with state and/or local laws. 5101:2-7-12(R)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
22.	Interior and exterior stairways accessible to children are protected by child safety gates or doors according to the child's age and functioning level. 5101:2-7-12(U)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
23.	Each foster child's bedroom has an outside wall window that should be screened and capable of opening and closing, unless the room has a fresh air ventilation system. 5101:2-7-05(B)(1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
24.	Bedrooms for foster children accommodate no more than four children. 5101:2-7-05(B)(2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
25.	Bedrooms for foster children provide reasonable access to an emergency exit. 5101:2-7-05(B)(6)	<input type="checkbox"/> Yes <input type="checkbox"/> No
26.	Bedrooms for foster children are not located on a floor higher than the second floor or in a basement unless approved in writing by a fire safety inspector. 5101:2-7-05(B)(7)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
27.	A bunk bed in use for a foster child is equipped with safety rails on the upper tier for a child under the age of ten years. 5101:2-7-05(F)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
28.	Cribs used for children under two years of age or under 35 inches in height are full-sized, with slats no more than 2 3/8 inches apart, no decorative cutout areas on crib end panels which could entrap a child's head, locks and latches on the drop side of the crib are safe and secure from accidental release or release by the child inside the crib, the mattress is at least 1 1/2 inches thick and covered with a waterproof material not dangerous to the child and fits close enough to the frame so that there is no more than one inch between the mattress and the sides of the crib. 5101:2-7-10(A)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
29.	If a bassinet is in use, it is used only for children under 3 months of age or less than 15 pounds in weight. 5101:2-7-10(B)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
30.	All vehicles used to transport foster children are covered by liability insurance in accordance with current state laws. 5101:2-7-15(A)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
31.	In accordance with the age and weight of foster children placed in the home, child restraint seats or booster seats are available for use in vehicles used to transport foster children. 5101:2-7-15 (D)(E)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Assessor and Supervisor Action: Check one or both boxes below and sign the form indicating approval or need for a fire safety inspection

- I. I certify that based on my observations of this home on this date, this home appears to be reasonably safe for placement of a foster or adoptive child(ren).
- II. Based on my observations of this home on this date, the foster caregiver will be required to secure a fire safety inspection pursuant to rules 5101:2-5-20 or 5101:2-5-24 of the Ohio Administrative Code before a decision can be made regarding recertification. Pursuant to rule 5101:2-5-30 a fire safety inspection is required within 90 days of the relocation of any foster home.

Agency Assessor Signature	Date
Supervisor Signature	Date
Date Fire Safety Inspection Was Conducted	

Note: Completion of this form is required by Chapter 5101:2-5 or Chapter 5101:2-48 of the Ohio Administrative Code.



ADOPTIVE APPLICANT

MEDICAL/PSYCHOLOGICAL INFORMATION RELEASE

We/I, _____ give my/our written permission to authorize any physician group, clinic, hospital, mental health professional or association, or social service/adoption agency and its employees to release any or all medical (specifically including HIV test results)/psychological/social information it may have about me to ADOPTION CIRCLE. This release allows any of the above to discuss our/my medical/psychological/social status with ADOPTION CIRCLE.

Further, we/I authorize ADOPTION CIRCLE to use and disseminate any or all of my medical (specifically including HIV test results)/psychological/social information it may acquire to any prospective birthparents, physician group, clinic, hospital, mental health professional or association, other social service agency and the employees thereof.

A copy of this release shall be as effective as the original.

Signature

Date

Signature

Date

AMYCOP/MEDPSYRELA-Rev. 7/09