

1

**FOSTER CARER APPLICATION FORM**

**MERCYCARE FOSTERING SERVICES:**

38 Ord Street, West Perth WA 6005 PO Box 202, Wembley WA 6913

Phone: 08 9340 7206

# APPLICANT 1: NAME:

**APPLICANT 2: NAME:**

Part 1 - *Pages 2 - 5* TO BE COMPLETED BY

## APPLICANT 1

Part 2 - *Pages 6 -9* TO BE COMPLETED BY

## APPLICANT 2

Part 3 - *Pages 10 - 12* TO BE COMPLETED BY

## APPLICANT 1 & APPLICANT 2

***(If more than one applicant, please complete jointly)***

**As a fostering agency, MercyCare Fostering Services aims to provide loving and stable homes to children and young people who have had a difficult start to life, and as a result of this, often suffer from trauma and attachment issues. Children in care really need foster families who have a lot of time and energy to help them heal.**

**The information provided in this application form will assist MercyCare as part of its assessment, so it is important that your responses are as detailed as possible.** In accordance with the *Privacy Amendment (Privacy Sector Act 2000),* the personal information collected about families will be used in a confidential manner strictly for the purpose of facilitating a foster care assessment.

We appreciate your interest in fostering and for taking the time to complete this application form. We will seek to assess your application as quickly as possible.

***If you need any clarification about completing this form, please contact MercyCare on (08) 93407206.***

**PART ONE: APPLICANT ONE**

# PERSONAL DETAILS:

Surname First name/s

Maiden Name (if applicable)

Address P/C

Length of time at this address Period of residence in WA (years)

Phone (H) (W) (M)

Email

Date of birth Place of birth

Aboriginal/Torres Strait Island: Y N Ethnicity/Citizenship

Region/beliefs Practising: Y N

Would you accept a child who was not willing/able to attend your current place of worship? Y N

# CURRENT MARITAL STATUS:

Never Married Y

Married Date Place of Marriage (State/Country)

Defacto Date

*Separations in present relationship:* Y N *Date/s of separation* Widowed Date Length of marriage (yrs) Divorced Date Length of marriage (yrs) Separated Date Length of marriage (yrs) *Previous Name (if different to current)*

# CURRENT EMPLOYMENT:

Occupation Employer

Usual hours of work Length of current employment

Shift Work: Y N Centrelink benefit: Y N - If yes, type of benefit

*Please indicate previous employment history:*

Employer Job Title Date

Employer Job Title Date

Employer Job Title Date

# CHILDREN:

*Please list all children from present and previous marriages*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Surname** | **Name** | **M/F** | **Age** | **DOB** | **Currently living at Home**  **Y N** |
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|  |  |  |  |  |  |

***Apart from fostering, are you planning on having more children?***

***Please list any other adults or children residing in your home on a regular basis (3 plus consecutive nights)***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **DOB** | **M/F** | **Relationship** |
|  |  |  |  |
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**SCREENING:**

**Criminal and Department for Child Protection record checks will be undertaken as part of the screening process.**

**Answering yes to either of the following questions below does not automatically preclude you from fostering.**

* Have your, or any members of your family, ever had contact with the Department for Child Protection? Y N ***If yes, please briefly state when and why***
* Have you ever been investigated for, or charged with, acriminal office? Y N

***If yes, please state what and when:***

**GENERAL:**

Do you drive? Y N Do you have your own car? Y N

Driver’s licence number: Expiry date:

Please list your interests and hobbies:

# HEALTH:

Many applicants have health or medical issues. It is important we are aware of issues so that we don’t put your health or that of your family at risk. Existing health or medical issues will not necessarily prevent you from becoming a carer. However, some existing health issues may help determine the type of child placed in your care.

## How would you describe your health (Please circle)

* 1. Excellent (b) Good (c) Fair (d) Poor

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you had any of the following:**  *(Tick the appropriate box)* | **No** | **Yes** | **If yes, date** |
| High blood pressure |  |  |  |
| Pains in the chest |  |  |  |
| Rheumatic fever or heart complaint |  |  |  |
| Asthma, RB or Lung Disease |  |  |  |
| Epilepsy |  |  |  |
| Muscular, Skeletal problems |  |  |  |
| Kidney or bladder disease |  |  |  |
| Cancer or tumour of any kind |  |  |  |
| Diabetes |  |  |  |
| Visual difficulties |  |  |  |
| Hearing difficulties |  |  |  |
| Major surgery |  |  |  |
| Psychological/Psychiatric disorders |  |  |  |
| Fertility treatment |  |  |  |

Do you drink alcohol? Y N If yes, daily quantity

Do you smoke? Y N If yes, how many per day

|  |  |  |  |
| --- | --- | --- | --- |
| **During last five years, have you:** | **No** | **Yes** | **If yes, details:** |
| Been hospitalized? |  |  |  |
| Used any medication on a regular basis? |  |  |  |
| Had a proposal for Life, Accident or Sickness Insurance on your life declined, deferred by, or withdrawn from any Insurance company, or accepted with a loading? |  |  |  |
| Had any other illness? |  |  |  |

Do any of **your children** have any medical condition?

Child Condition Child Condition

Do any of **your children** have any psychological or behavioural problems?

Child Specify Child Specify

# YOUR DOCTOR:

*As part of the assessment, we ask for feedback from your doctor, as a duty of care to you. Medical conditions will not necessarily preclude you from becoming a foster carer, however it is valuable for us to know about health issues, so that we can assess your capacity as potential carers (e.g. we may not place a baby or toddler with foster carers with back issues as this may exacerbate their condition).We will only contact your GP once you have signed the Consent for release of medical information form at the time of the initial visit.*

Doctor’s Name Medical Practice

Phone

Address Suburb Postcode Last time you attended a medical appointment with your Doctor: Month Year

# REFEREES:

*Please give names and addresses of two persons, not related to you, willing to provide character references.* ***Couples may use same referees as long as they know both parties.*** *Referees should have known you for at least two years.*

*Please complete the postal address in full as we will be mailing out a reply-paid envelope to your nominated referees.*

Name: Phone: Relationship to you: Email: Address Suburb Postcode

Name: Phone: Relationship to you: Email: Address Suburb Postcode

*If you are, or have been previously employed in a* ***child related occupation*** *please add your employer as a referee:*

Name: Title:

Company/Organisation: Phone: Address Suburb Postcode

**PART TWO: APPLICANT TWO**

# PERSONAL DETAILS:

Surname First name/s

Maiden Name (if applicable)

Address P/C

Length of time at this address Period of residence in WA (years)

Phone (H) (W) (M)

Email

Date of birth Place of birth

Aboriginal/Torres Strait Island: Y N Ethnicicity/Citizenship

Region/beliefs Practising: Y N

Would you accept a child who was not willing/able to attend your current church? Y N

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| **Surname** | **Name** | **M/F** | **Age** | **DOB** | **Currently living at Home**  **Y N** |
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***Apart from fostering, are you planning on having more children?***

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* Have you ever been investigated for, or charged with, a criminal office? Y N

***If yes, please state what and when:***

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Driver’s licence number: Expiry date:

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| Asthma, RB or Lung Disease |  |  |  |
| Epilepsy |  |  |  |
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| Kidney or bladder disease |  |  |  |
| Cancer or tumour of any kind |  |  |  |
| Diabetes |  |  |  |
| Visual difficulties |  |  |  |
| Hearing difficulties |  |  |  |
| Major surgery |  |  |  |
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| Fertility treatment |  |  |  |

Do you drink alcohol? Y N If yes, daily quantity

Do you smoke? Y N If yes, how many per day

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| --- | --- | --- | --- |
| **During last five years, have you:** | **No** | **Yes** | **If yes, details:** |
| Been hospitalized? |  |  |  |
| Used any medication on a regular basis? |  |  |  |
| Had a proposal for Life, Accident or Sickness Insurance on your life declined, |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| deferred by, or withdrawn from any Insurance company, or accepted with a loading? |  |  |  |
| Had any other illness? |  |  |  |

Do any of **your children** have any medical conditions?

Child Condition Child Condition

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Child Specify Child Specify

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Name: Phone: Relationship to you: Email: Address Suburb Postcode

*If you are, or have been previously employed in a* ***child related occupation*** *please add your employer as a referee:*

Name: Title:

Company/Organisation: Phone: Address Suburb Postcode

**PART THREE**

**IF MORE THAN 1 APPLICANT, THIS SECTION TO BE COMPLETED JOINTLY**

## FOSTERING:

**Have you ever applied to care for children previously?** Yes No

*If yes, when and with whom:*

## What are your motivations to care for a foster child?

**Do you know of any families with foster children?**

**Why do you think children need to be in foster care?**

**What difficulties/problems do you think children in foster care would have?**

**What role do you think the child’s parents play when their children are in care?**

**What do you think you will gain from being a foster carer?**

**Have you discussed this application with family and friends?** Y N

*If yes, what was their reaction*:

**Taking into account your lifestyle, what age/gender/type of care** *(short term, Medium term, long term)* **do you think would fit most happily into your family and why?**

## What sorts of things could you and/or your family offer a child/young person in foster care?

**Do you believe you are in a financial position to be able to support a child being with you? Foster carers are provided with a small subsidy to meet the basic needs of a child in their care (e.g. food, day-to-day expenses)**

**How did you hear about MercyCare Fostering Services?**

**Many foster care applicants have some worries/questions about what they are letting themselves in for.** *What are yours?*

**PRACTICAL CONSIDERATIONS:**

Please describe your house and garden

|  |  |  |
| --- | --- | --- |
| Do you have a spa, a pool or other body of water?  *If yes, do you have 1.2m fencing around the spa/pool* | Yes  Yes | No  No |
| Is there a spare room in your home for a child? | Yes | No |
| Do you have pets? | Yes | No |

*If yes, please list:*

Signature Date

Signature Date