DEPARTMENT FOR COMMUNITY BASED SERVICES
DIVISION OF FAMILY SERVICES

NEW FOSTER/ADOPTIVE PARENT VERIFICATION

SSN: _____

First Name: _____

Middle: _____

Last Name: _____

Sex: _____

DOB (mm/dd/yy): _____

Mailing Address: _____

City: _____

County: _____

Home Phone: _____

Email: _____

Years of Education: _____
(If GED, enter 12)

Hours Employed Per Week: _____

Work Phone: _____

Hispanic Origin: _____

- **01 - Yes**
- **02 - No**
- **03 - Unable to Determine**

Race: _____

- **01 - White**
- **02 - Black**
- **03 - American Indian/Alaskan Native**
- **04 - Asian/Pacific Islander**
- **05 - Unable to Determine**

Home Address: _____

State: _____ Zip: _____

Region: _____

Inquiry Date: _____

Informational Date: _____

Approval Date: _____

Subsidy Date: _____

Pre-Subsidy Date: _____

Post-Subsidy Date: _____

Type of Home: _____

- **01 - Basic**
- **02 - Advanced Basic**
- **03 - Medically Fragile**
- **04 - Family Treatment**
- **05 - Emergency Shelter**
- **06 - Relative**

Type of Parent: _____

- **01 - Foster**
- **02 - Foster/Adoptive**
- **03 - Adoptive**
- **04 - Adoption Subsidy**
- **05 - Foster/Adoption Subsidy**
- **06 - Foster/Adoptive/Adoption Subsidy**
- **07 - Adoptive/Adoption Subsidy**

R&C Worker:

SSN: _____

Name: _____

TWIST Number: _____

Vendor Number: _____