DPP-198
(Rev. 8/2020)

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Protection and Permanency

Foster Parents Statement of Intent to Adopt

Family: _____

Address: _____

City: _____ Zip code: _____ County: _____

Telephone: _____

I/we state that my/our family is interested in adopting a child(ren) through the Department for Community Based Services (DCBS) who is currently placed in my/our home for through foster care.

Child's name: _____ DOB: _____

Child's name: _____ DOB: _____

Child's name: _____ DOB: _____

I/we understand that this child(ren) is not available for adoption, nor is the agency promising that we will be able to adopt the child(ren) but that there are factors involved in the child(ren's) background which may indicate a possibility that the child(ren) may become available for adoption in the future. I/we understand that a child does not become available for adoption until the rights of the alleged and legal parents have been terminated through court action.

I/we understand that if difficulties develop regarding the child(ren) becoming a member(s) of my/our family, I/we will be advised during the process.

I/we agree to cooperate with the DCBS social worker in any reunification plans.

I/we understand that if the child(ren) becomes eligible for adoption, and if all parties agree that the child(ren) has satisfactorily adjusted to my/our home, DCBS plans to then place the child(ren) with my/our family on an adoptive basis.

I/we have read the foregoing and agree to the above statements. The terms of this agreement shall remain in force until changed by mutual agreement of all parties or when the child(ren) is removed from the home.

_____	_____
Signature of foster parent	Date
_____	_____
Signature of foster parent	Date
_____	_____
Signature of agency representative and title	Date

(Note: For PCP adoptions only)

_____	_____
Signature of PCP representative and title	Date