Minnesota Adoption and Foster Care

Individual Fact Sheet

NAME OF PERSON COMPLETING FORM	NAME OF APPLICANT/LICENSE HOLDER

Instructions: Family child foster care and adoption applicant(s), license holders, and all adult household members (age 18 and older) are required to complete this form at initial application for a child foster care license or adoption home study, adoption home study update, or at child foster care relicensure.

Do you have a history of, or are you currently experiencing any of the following?

Yes	No	Sexual, physical or verbal abuse, or domestic violence.
Yes	No	Individual and/or family/group counseling.
Yes	No	Treatment or hospitalization for mental health concerns.
Yes	No	Criminal charges and/or convictions for any offense (including as a juvenile), even if dismissed.
Yes	No	Arrest by law enforcement, or probation/parole.
Yes	No	Involvement with social service departments, including child protection.
Yes	No	Investigation for neglect or abuse of a child or a vulnerable adult.
Yes	No	Out-of-home placement of your own minor children.

If you selected yes to any of the above, explain:

Physical and chemical health statements

1. Do you have any health conditions for which you need medical care?

Yes No

If yes, describe all health conditions you have and the medical care you are receiving:

2. Do you have health conditions that may pose a risk to a child's health or would limit your physical ability to care for foster children?

Yes No

If yes, describe the risks or limitations:

3. Are there minor children living in the home (do not include children in placement)?

◯ Yes ◯ No

4. Do minor children have any health conditions for which they need medical care?

◯ Yes ◯ No

If yes, describe all health conditions, the medical care they are receiving, and whether or not the condition may pose a risk to foster children:

5. Have you ever experienced any chemical use problems, including alcohol abuse, abuse of prescription controlled substances, and use of illegal substances?

◯ Yes ◯ No

If yes, describe: (e.g., how long ago, what happened, was treatment recommended, did you attend treatment and/or Alcoholics Anonymous, etc.)

6. Have you been free of chemical use problems for the past two years?

◯ Yes ◯ No

If no, explain:

Signature

I understand that failure to provide complete and true information on the individual fact sheet may result in denial of my child foster care application; revocation of my child foster care license; or termination of adoption services.

SIGNATURE OF PERSON COMPLETING FORM	DATE

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တက့်. ဖဲနမ့်လိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာ်မီတခါးဆံၤန္ဉ်,ကိးဘဉ်လီတဲစိနိ်ဂ်ံလၢထးဆံၤန္ဉ်တက့်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA4 (9-15)

For accessible formats of this publication, ask your county worker. For assistance with additional equal access to human services, contact your county's ADA coordinator.

Civil Rights Notice

Discrimination is against the law. The Minnesota Department of Human Services (DHS) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- marital status
- age
- disability
- sex
- political beliefs

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by a social services agency.

Contact **DHS** directly only if you have a **discrimination** complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
Freeman Building, 625 North Robert Street
St. Paul, MN 55155
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion

Contact the **OCR** directly to file a complaint:

Director
U.S. Department of Health and Human Services'
Office for Civil Rights
200 Independence Avenue SW
Room 509F
HHH Building
Washington, DC 20201
800-368-1019 (voice)
800-537-7697 (TDD)
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf