GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
(DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT)

Post Office Box 2816 Hagåtña, Guam 96932
123 Chalan Kareta, Route 10
Mangilao, Guam 96923

Felix P. Camacho
GOVERNOR

aleo S. Moylan
:UTENANT GOVERNOR

PeterJohn D. Camacho,MPI
DIRECTOR

DEPUTY DIRECTOR

WELCOME!

The Bureau of Social Services Administration (BOSSA) of the Division of Public Welfare, Department of Public Health and Social Services (DPHSS) welcomes your interest in providing care to our foster children. Our children are in foster care because of either physical, emotional, sexual abuse or neglect in their family. Foster parents have an important and rewarding role that will directly impact, nurture and support the child's life while temporarily removed from their homes.

Individuals applying to become foster parents must be U.S. citizens or resident aliens and be residents of Guam (this includes active duty military personnel).

Who May Apply:

- Married couples
- Domestic partners (joint or alone)
- Single persons (including single parents) 18 years or older

If you meet the requirement above, please complete all the documents in the enclosed application packet and submit to the Bureau of Social Services Administration for processing. This will help us in certifying you as a prospective parent.

The application packet includes:

- Application for License
- Autobiography of Foster Parent Form
- Report of Medical History forms required for each applicant including tuberculosis clearance
- Employment Verification Form
- (3) Character Reference forms
- Consent for Disclosure Form

TEL. NO.: (671) 735-7399, 735-7171, 735-7119, 735-7173
FAX: (671) 734-5910

Commonwealth Now!

Families interested in our foster care program <u>must</u> submit the following:

- ☒ Guam Police Clearance
- ☒ Copy of recent check stub
- ☒ Marriage certificate/license if applicable
- ☒ Clearance from investigative agency (i.e. Navy Criminal Investigative Services, Offices of Special Investigation) if active duty military personnel

<u>What to Expect:</u>

A social evaluation of the application and home environment will be conducted by our agency to assess the applicant's personal character, fitness and factors which show competency for the care of foster children.

If an applicant has satisfactorily met the above requirements, the Department will issue a certification showing approval for licensing a family foster home. The license is valid for 2 years.

We need dedicated families that will meet the challenging needs of our children. We appreciate your time and consideration and we look forward to hearing from you.

You may contact us at:

<u>Mailing Address:</u>
Bureau of Social Services Administration
Division of Public Health and Social Services
P.O. Box 2816
Hagatna, Guam 96932

<u>Telephone Numbers:</u>
(7671) 475-2672/2653

<u>Facsimile Number:</u>
(671) 472-6649

AUTOBIOGRAPHY OF FOSTER PARENT

NAME OF APPLICANT(S): ______________________________________
ADDRESS ____
TEL.: ____________ **(Home)**_______________ **(Work)**____________ **(Other)**

I. Who initiated the idea of being a foster parent and who is most interested?

What are your reasons for wanting to be a foster parent?

What was your upbringing like? (Describe your parents' attitude toward child rearing and your family' relationship to one another).

How much contact do you have with your own family now?

II. MARITAL RELATIONSHIP:

How are decisions made and who makes them?

As a couple, what are your strengths and weaknesses?

How do you deal with difficult issues when they come up?

III. CHILD REARING:

What method(s) of discipline do you practice? Under what circumstances would you apply them?

What behaviors do you expect from children, during meals and playtime?

What behaviors or expectations do you have with regards to teenagers?

IV. RELIGION:

What are your feelings on religion or morals? How does it relate to child rearing?

I certify that the above is true and correct to the best of my knowledge.

Signature ___________________________________Date: _______________

Jdc4/02

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINISTRATION
P.O. BOX 2816
HAGATNA, GUAM 96910
Telephone: (671) 475-2653/2672
Facsimile: (671) 472-6649

APPLICATION FOR LICENSE: *(check those which apply)*

- ☐ FAMILY FOSTER HOME (1-6 Children)
- ☐ FAMILY DAY CARE (1-6 Children)
- ☐ GROUP DAY CARE (7-12 Children)
- ☐ CHILD CARE CENTER/NURSERY (13 or more Children)
- ☐ RESIDENTIAL TREATMENT FACILITY FOR CHILDREN

A. NAME OF FACILITY ______________________________
(name to appear on license)

Residential Address: ______________________________
Mailing Address: ______________________________
Telephone Number: ______________________________

B. TYPE OF OWNERSHIP: ☐ Individual ☐ Partnership ☐ Association ☐ Corporation

C. FOR CHILD CARE FACILITY SPONSORED BY GROUP / ORGANIZATION:

Name of Sponsoring Organization: ______________________________
Address: ______________________________
Name of Chairperson of the Board of Directors: ______________________________
Address: ______________________________
Telephone No. ______________________________

D. TYPE OF INSURANCE COVERAGE: ______________________________

BEFORE COMPLETING ITEMS I-V, YOU MAY WISH TO DISCUSS YOUR SITUATION WITH A LICENSING WORKER.

I. NUMBER OF PERSONS TO BE GIVEN CARE: ________ **AGE RANGE:** _____**TO**_____
NUMBER OF DAYS PER WEEK ________ **WILL FEES BE CHARGED?** ____________
WILL YOU ACCEPT EMERGENCY FOSTER CARE? ______________________________

II. GIVE A STATEMENT OF YOUR PURPOSE FOR OFFERING THIS SERVICE:

____
____

III. DESCRIBE PROGRAMS and ACTIVITIES DESIGNED TO ACCOMPLISH THE ABOVE STATED PURPOSE.

____
____

IV. DESCRIPTION OF BUILDING TO BE USED: *(check where applicable)*

☐ Building Occupied by Family — Number of Bedrooms: ____________
☐ Building Not Occupied by Family
Amount of Indoor Space: ________sq. ft. Outdoor Space ________sq. ft.
(Excluding Bathroom, Kitchen, Cupboard Space and Hallways)

COMMENTS: ______________________________
____

V. REFERENCES: If sponsored by a NON-PROFIT organization, list three members of the Board; otherwise, list three references who know you.

1. ____________ (Name) ____________ (Telephone #) ____________ (Mailing Address & Zip)
2. ____________ (Name) ____________ (Telephone #) ____________ (Mailing Address & Zip)
3. ____________ (Name) ____________ (Telephone #) ____________ (Mailing Address & Zip)

______________________________ ______________________________
SIGNATURE OF APPLICANT **DATE**

1/04

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINISTRATION
P.O. Box 2816
Hagatna, Guam 96910

EMPLOYMENT VERIFICATION

Name: ______________________________

Employer: ______________________________

Hire Date: ______________________________

Position: ______________________________

Employment Status: ______________________________

Salary: ______________________________

Dates Paid: ______________________________

By: ______________________________ **Date:** ______________________________

To: **Personnel Department**

You are hereby authorized to release the above requested information to the Department of Public Health & Social Services.

______________________________ ______________________________
Signature of Employee **Date:**

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DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINISTRATION
P.O. Box 2816
Hagatna, Guam 96910

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Jdc4/02

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
Bureau of Social Services Administration
P.O. BOX 2816
HAGATNA, GUAM 96910
Tel. (671) 475-2653/2672 Fax: (671) 472-6649

CHARACTER REFERENCE FORM

Name of Client(s): ____

Type of Case: ( ) Adoption ( ) Custody ( ) Foster ( ) Other

This form is to be filled out by a reference (preferably non-relative) who has known the above-named client(s) for at least six months. The information submitted will assist us in assessing the capabilities of said client(s) as caretakers of children.

Length of time you have known: (please indicate name on the line/provide the length of time)

Mr. ______________________________ **Length of time:** __________

Mrs./Miss. ______________________________ **Length of time:** __________

Child(ren) ______________________________ **Length of time:** __________

Other ______________________________ **Length of time:** __________

Type of Relationship: (please indicate name on the line/provide length of time)

Friend(s) ______________________________ **Length of time:** __________

Co-Worker(s) ______________________________ **Length of time:** __________

Other ______________________________ **Length of time:** __________

How often do you meet? (specify if social, business, etc.)

____

____

____

____

____

Briefly describe your opinions of the above-named client(s): (i.e. character, personality traits, etc..)

____

____

____

____

____

Briefly describe in detail your observations of the interaction between the above-named client(s) and the child(ren) involved:

____

____

____

____

____

Based on your observations, what are your recommendations of the above-named client(s) regarding their capabilities in regards to serving the best interest of the child(ren). Please explain:

____

____

____

____

____

REFERENCE:

Name: ______________________________

Address: ______________________________

Telephone: **Home** ______________________

Work ______________________

Other ______________________

I certify that the above is true and correct to the best of my knowledge.

Signature: ______________________________ **Date:** ________________

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Bureau of Social Services Administration
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Jdc4/02

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REFERENCE:

Name: ______________________________

Address: ______________________________

Telephone: **Home** ______________________

Work ______________________

Other ______________________

I certify that the above is true and correct to the best of my knowledge.

Signature: ______________________________ **Date:** ______________

Jdc4/02

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
BUREAU OF SOCIAL SERVICES ADMINSTRATION

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

This information is to be released from records whose confidentiality is protected by Federal Law regarding right to privacy, which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information will not be sufficient for this purpose.

Name of program to give information: Department of Public Health & Social Services, Bureau of Social Services Administration, Child Protective Services Unit

Name of person or organization to receive information: DPHSS, BOSSA, Home Evaluation & Placement Section.

Name of Client: ______________________

Purpose or need for the disclosure (please be very specific): Home Evaluation Study for Foster Parent Certification.

Extent or nature of information to be disclosed (please be very specific): Child Abuse & Neglect Registry Check.

The Client may revoke this Consent for Disclosure of Client Information at any time. This Consent for Disclosure of Client Information shall have duration no longer than reasonably necessary to effectuate the purpose for which it is given.

______________________	______________________
Signature of Client/Guardian/Parent	**Signature of Person Requesting Information**
Date: ______________	**Date:** ______________

- -

I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE PERSON OR ORGANIZATION ABOVE AS OF:

______________________	______________________
Signature of Client/Guardian/Parent	Date:

GOVERNMENT OF GUAM INSPECTING AGENCIES

DEPARTMENT OF PUBLIC WORKS

Building Permit and Inspection
Administrator- Mr. Jesus Ninete
Permit Inspection Supervisor – Mr. Eddie Borja
Building B. Tumon
Telephone #: 646-3260/3142/31108
APPLICANT MUST COME IN FOR AN INSPECTIION SCHEDULE

GUAM FIRE DEPARTMENT
Tiyan 1-1301
Fire Prevention Bureau
Capt. Marquez
Telephone # 475-4534 Time: 8:00 a.m. to 11:30 a.m.

DIVISION OF ENVIRONMENTAL HEALTH, PH&SS
FOR NEW CONSTRUCTION, ALTERATION, OR CONVERSION, OR FOR EXISTING STRUCTURES TO BE USED AS A CHILD CARE FACILITIES.
REFER TO:
Supervisor: Rossana Rabago
Telephone # 735-7217

For issuance and renewal of sanitary permit or routine sanitary inspection refer to:

(1). Northern Region
Telephone # 635-7466

(2). Central Region
Telephone # 735-7399

(3) Southern Region
Telephone #: 828-7517

DEPARTMENT OF LAND MANGEMENT
Zoning Division-One Stop,Center
Across Pigo Cemetary (Former Revenue & Taxation Building)
Chief Planner: John T. Anderson
Planner IV: Joe T. Cruz
Planner III: Rudy Cabana
Telephone # 475-5259
NOTE: ATTACH TO YOUR APPLICATION FORM THE ZONING CLEARANCE TO EXPEDITE SIGNATURE NEEDED

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
BUREAU OF SOCIAL SERVICES ADMINISTRATION
LICENSING UNIT

CERTIFICATION OF COMPLIANCE WITH PUBLIC LAW 11-99
(SUB-CHAPTER C-1 OF CHAPTER VI, TITLE X, GOVERNMENT CODE OF GUAM)

____
NAME OF CHILD CARE/ADULT CARE FACILITY

____
NAME OF OPERATOR

____
ADDRESS OF FACILITY OR OPERATOR

This facility conforms to those portions of Public Law 11-99 and to other applicable Government of Guam Laws, Codes, or Regulations relating to building standards.

____
BUILDING INSPECTOR

____
DATE

This facility conforms to those portions of Public Law 11-99 and to other applicable Government of Guam Laws, Codes, or Regulations relating to building standards.

____
TERRITORIAL PLANNING COMMISSION
DEPARTMENT OF LAND MANAGEMENT

____
DATE

This facility conforms to those portions of Public Law 11-99 and to other applicable Government of Guam Laws, Codes, or Regulations relating to building standards.

____
COMMANDER, FIRE OPERATIONS BUREAU
INSPECTOR

____
DATE

This facility conforms to those portions of Public Law 11-99 and to other applicable Government of Guam Laws, Codes, or Regulations relating to building standards.

____
ENVIRONMENTAL HEALTH SPECIALIST

____
DATE

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC WELFARE
GOVERNMENT OF GUAM
HAGATNA, GUAM

REPORT OF MEDICAL HISTORY

NAME: ____________________ **SEX:** __________ **MARITAL STATUS:** ____________

DATE OF BIRTH: ___________ **PLACE OF BIRTH:** ________ **CITIZENSHIP:** _________

- **Please complete this form and take it with you to your Physician for examination.**

FAMILY HISTORY

Has any of your family members or relatives ever had a history of the following ailments?

Family Member	Age	State of Health	Age at Death	Cause of Death	Aliment	YES	NO	Relationship
FATHER					TUBERCULOSIS			
MOTHER					DIABETES			
BROTHER (S)					ARTHRITIS			
					EPILEPSY			
					CONVULSIONS			
					HEART DISEASE			
					KIDNEY DISEASE			
SISTER (S)					HIGH BLOOD PRESSURE			
					STOMACH/ ABDOMINAL AILMENT			
					ASTHMA HAY FEVER			
					OTHER DISEASE (S)			

PERSONAL HISTORY

Please indicate YES or NO for all questions. Make appropriate comments in the space provided below or on a separate sheet of paper.

Have you ever had....	YES	NO	Have you ever had...	YES	NO	Have you ever had...	YES	NO
SCARLET FEVER			CHEST PAIN			INSOMNIA (can't sleep)		
RHEUMATIC FEVER			SHORTNESS OF BREATH			ANXIETY WORRY		
MEASLES			ASTHMA			DEPRESSION		
GERMAN MEASLES			HAY FEVER			NERVOUSNESS		
MUMPS			ALLERGY			STOMACH/ ABDOMINAL AILMENTS		
CHICKEN POX			TUBERCULOSIS			DIARRHEA		
MALARIA			TUMOR OR CANCER			DIZZINESS FAINTNESS		
RECENT GAIN OR WEIGHT LOSS			JAUNDICE			PALPITATION		
ANY SURGERY						HEADACHES		
						COLDS/SORE THROAT		

PHYSICIAN'S CERTIFICATION

Based on my examination of ______________________________ on ____________ 2002
NAME

I Certify that this person is [ ] free from infectious disease and in good health [ ] Temporarily until ___________

[ ] In poor health but able to maintain employment [ ] Permanently

[ ] In poor health and unable to maintain employment

ACTIVITIES TO BE AVOIDED [ ] Lifting [ ] Pushing [ ] Standing [ ] Climbing [ ] Walking [ ] Other __________

PHYSICIAN'S SIGNATURE **CLINIC/HOSPITAL** **DATE**