Family Pathways

Striving to Strengthen Relationships

HEALTH HISTORY

Have you ever had any of the following?

RESOURCE CAREGIVER	PARENTING PARTNER
Fainting spells?	Fainting spells?
Allergies?	Allergies?
Convulsive seizures?	Convulsive seizure?
Diabetes?	Diabetes?
Hepatitis?	Hepatitis?
Rheumatic fever?	Rheumatic fever?
Tuberculosis?	Tuberculosis?
Other diseases affecting the lungs or heart (specify)?	Other diseases affecting the lungs or heart (specify)?
Diseases or disorders of the nervous system (specify)?	Diseases or disorders of the nervous system (specify)?
Hospitalization history:	Hospitalization history:
List of Medications and Purpose:	List of Medications and Purpose:

Does your age, physical and/or mental health limit the number and/or type of child/ren you would be able to care for? _____Yes _____ No

A resource parent must have a demonstrated stable mental and emotional adjustment. If a question arises regarding the mental or emotional stability of a family member which might have a negative effect on a foster child, Family Pathways shall require a psychological evaluation of that person before approving the resource home.

_____ _____

Resource Caregiver's Signature
Date: _____

Parenting Partner's Signature
Date: _____

_____

Coordinator/Facilitator's Signature
Date: _____

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PENDING WATER ANALYSIS

☐ City Water ☐ Well water

If Well Water:

I understand that until the water test is returned approved, bottled water must be provided for drinking, cooking, and brushing of teeth for all children in placement. If your water test does not pass, you will need to make diligent efforts to obtain a passing water test.

I understand that if the water test does not pass prior to the certification date, I will be unable to be certified as a resource caregiver.

_____
Resource Caregiver's Signature
Date: _____

_____
Parenting Partner's Signature
Date: _____

_____
Coordinator/Facilitator's Signature
Date: _____

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FINANCIAL SUMMARY

Gross Annual Family Income: _____

Source(s): _____

Applicant must provide a clear copy of the following:

- W-2 statement and/or two pay stubs
- Social Security Statements: Sign in and create account at www.socialsecurity.gov/myaccount

Is your income, without the stipend from foster/kinship care, adequate for meeting the family's needs?

_____

_____

_____

As a resource caregiver I will receive a daily stipend of _____ per child. I understand that this stipend will be used to meet the needs of the foster/kinship child/ren in our home. This stipend will be used for daily living expenses, child care, clothing, food, transportation, extracurricular activity expenses, field trips, etc. The stipend is to incorporate all expenses you incur while the child is in your care.

Is your family financially able to meet the needs of the foster/kinship child with the stipend?

_____

_____

_____

_____ As a resource caregiver, will you provide good quality clothing and allot $2.00 per
initial
day of the stipend for clothing? _____Yes _____ No

_____ As a resource caregiver, will you give and withhold allowance properly and allot
initial
$2.00 per day of the stipend for the child's allowance? _____Yes _____ No

_____
Resource Caregiver's Signature
Date: _____

_____
Parenting Partner's Signature
Date: _____

_____
Coordinator/Facilitator's Signature
Date: _____

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ACKNOWLEDGEMENT OF RECEIPT

_____It has been determined that resource parents are to be in compliance with regulations by reading the "Resource Family Care Act" (Act of 2005, P.L. 404, No. 73). I acknowledge receipt of the "RESOURCE FAMILY CARE ACT" and agree to read the Act.

_____I hereby acknowledge that I have been provided with the Agency's NOTICE OF PRIVACY PRACTICES and agree to read the Notice.

_____I have been provided with and agree to read the FAMILY PATHWAYS' RESOURCE FAMILY POLICIES AND PROCEDURES MANUAL.

_____
Resource Caregiver's Signature
Date:_____

_____
Parenting Partner's Signature
Date:_____

_____
Coordinator/Facilitator's Signature
Date:_____

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Striving to Strengthen Relationships

Consent for Release of Information

Name of Client: _____ **D.O.B:** _____
Client Address: _____
Client Telephone: _____

I hereby authorize Family Pathways (please check):

_____ To **Release** information from the records of _____ to the Name and Address below to include:

_____ To **Obtain** information from the records of _____ from the Name and Address below to include:

- ☐ **All Records**
- ☐ Social History
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Therapy Notes
- ☐ Medication Maintenance
- ☐ Discharge Summary
- ☐ Lab Reports
- ☐ Verbal Communication
- ☐ Dates of Service
- ☐ Medical Records
- ☐ Other: Specify

For the Purpose of: Case Management Communication
Name of Agency: _____
Address: _____
Phone: _____

I understand the following:

- That my records are protected under applicable federal and state regulations and that I have been provided with a copy of the *Notice of Privacy Practices*.
- That my health records will not be released or obtained by Family Pathways unless my permission is given as authorized by my signature below.
- That release of my health records will be for the purpose stated on this form and only the items indicated will be released.
- That the health records released by agency/person above may possibly be re-disclosed by the outside agency that receives the records and therefore Family Pathways has no further responsibility as a result of the re-disclosure and that such information would no longer be protected by the Privacy Rule.
- That this release is valid from only date: _____ to date: _____ and should not exceed **1 year** unless specified to be used for school consultation in a given school year for a specific named school. **This information is limited to the dates specified.**
- That I have a right to revoke this authorization at any time by sending a written note to the agency.
- That my decision to revoke authorization does not apply to any prior records that were sent after being authorized for release.
- That I am entitled to a copy of this form. **I have accepted a copy of this form: _____ Yes _____ No**

I affirm that _____ was physically unable to sign the above consent. I verbally indicated this voluntary consent to treatment and fully understand the nature of the release.

_____ _____
Signature of Client, legal guardian or POA Date

_____ _____
Coordinator/Facilitator's Signature Date

Family Pathways

Striving to Strengthen Relationships

Consent for Release of Information

Name of Client: _____ **D.O.B:** _____
Client Address: _____
Client Telephone: _____

I hereby authorize Family Pathways (please check):

_____ To **Release** information from the records of _____
to the Name and Address below to include:

_____ To **Obtain** information from the records of _____
from the Name and Address below to include:

- ☐ **All Records**
- ☐ Social History
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Therapy Notes
- ☐ Medication Maintenance
- ☐ Discharge Summary
- ☐ Lab Reports
- ☐ Verbal Communication
- ☐ Dates of Service
- ☐ Medical Records
- ☐ Other: Specify

For the Purpose of: Case Management Communication
Name of Agency: _____
Address: _____
Phone: _____

I understand the following:

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- That I am entitled to a copy of this form. **I have accepted a copy of this form: _____ Yes _____ No**

I affirm that _____ was physically unable to sign the above consent. I verbally indicated this voluntary consent to treatment and fully understand the nature of the release.

_____ _____
Signature of Client, legal guardian or POA Date

_____ _____
Coordinator/Facilitator's Signature Date

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DISCIPLINE IN THE RESOURCE FAMILY HOME

- Foster/Kinship children shall be directed with techniques that stress praise and encouragement.
- Foster/Kinship children may not be subjected to verbal abuse, derogatory remarks or threats of removal from the foster/kinship home.

PUNISHMENT: The following forms of punishment are ***prohibited***:

- Abusive discipline practices.
- Physical punishment inflected upon the body.
- Punishment for bed-wetting or actions related to toilet training.
- Denial of meals, clothing or shelter.
- Denial of elements of the service plan or ISP.
- Denial of communication with, or visits by, the child's family as per Court Order and/or CYS guidelines.
- Assignment of physically strenuous exercise or work solely as punishment.
- Require a child to remain silent for long periods of time.
- Another child residing in the home cannot delegate punishment to the foster child/ren.
- Physical restraint, isolation or the use of security or physical barriers which prohibit a child's egress. Locks may be used as a means of external security to keep persons out or deny access to a certain area of the home.

_____
Resource Caregiver's Signature
Date:_____

_____
Parenting Partner's Signature
Date:_____

_____
Coordinator/Facilitator's Signature
Date:_____

Family Pathways

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Drug, Alcohol and Smoking Policy

Family Pathways has a zero tolerance on this issue. The use or abuse of illegal substances is strictly forbidden in formal resource caregiver homes participating in permanency services of Family Pathways. Resource caregivers (or other residents in the home) may be asked to submit to random drug testing during their participation in the resource caregiver program (as a pre-adoptive placement) as a precaution, or if concerns are raised. **Refusal to participate in testing will be noted and considered a positive screen. Any positive screens will result in the immediate termination of your participation in the resource caregiver program with a recommendation for removal of the children. Please be advised that all findings and recommendations will be forwarded to the local Children and Youth Agency.**

The primary role of the pre-adoptive/resource caregiver and Family Pathways is to ensure the safety of the child/ren entrusted to our care. Safety is hindered when illegal drugs and/or excessive amounts of alcohol are consumed in any home. It is Family Pathways' position that caregivers are responsible for monitoring the safety of the child/ren in their care at all times; ensuring that illegal drug and/or alcohol abuse is not an issue within their home environment.

As of September 11, 2008 the Clean Indoor Air Act became law in Pennsylvania. This act impacts individuals who provide child care, adult day-care and/or services related to the care of children and youth in the state or county custody in foster care of kinship care. **Individuals providing care are not permitted to smoke in a residence or vehicle when a foster or kinship child is present. We are asking that all smoking occur outside of the resource caregiver's residence.**

_____ _____

Resource Caregiver's Signature
Date:_____

Parenting Partner's Signature
Date:_____

_____

Coordinator/Facilitator's Signature
Date:_____

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NON-DISCRIMINATION IN SERVICES

Admissions, the provision of services and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age or sex.

Program services shall be made accessible to persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any client (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with any of the following:

Family Pathways
100 Brugh Avenue
Butler, PA 16001

Bureau of Equal Opportunity
Department of Human Services
Room 223 Health and Welfare Building
PO Box 2675
Harrisburg, PA 17105

Office of Civil Rights
Department of Human Services
Office for Civil Rights Region III
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-9111

Pennsylvania Human Relations Commission
301 Fifth Avenue
Suite 390, Piatt Place
Pittsburgh, PA 15222

Bureau of Equal Opportunity
Department of Public Welfare
Western Regional Office
301 Fifth Avenue
Suite 410, Piatt Place
Pittsburgh, PA 15222

_____
Resource Caregiver's Signature
Date:_____

_____
Parenting Partner's Signature
Date:_____

_____
Coordinator/Facilitator's Signature
Date:_____

Family Pathways

Striving to Strengthen Relationships

RESOURCE PARENT COMMITMENT

_____The resource caregiver agrees to share ***accurate*** and ***timely*** information to Family Pathways concerning the child/ren's participation in visitation with their biological family; all their health related appointments, and their educational progress. ***Biological parents will be notified of all medical, mental health (therapy) and education appointments.***

_____The resource caregiver agrees to share with Family Pathways recreational/family/extra-curricular activities that the child/ren are enrolled or participate in. The resource caregiver must discuss with their Family Pathway's Facilitator the process of making the decision to participate in these activities utilizing the prudent parenting standard process.

_____The resource caregiver agrees to provide any and all transportation for the children in their care.

_____The resource caregiver agrees to comply with the visitation schedule as outlined by the Court Order and/or Children and Youth Services, as well as the service provider monitoring/supervising the visits.

_____The resource caregiver agrees to follow Family Pathways policies and procedures.

_____The resource caregiver agrees that at any time Family Pathways has a concern about the condition of the caregiver's home (i.e. cleanliness, safety concerns, or animal feces), photographs may be taken of the home for the sole purpose of reviewing certification.

_____The resource caregiver agrees they have received a copy of the Emergency Room Visit Protocol and agree to follow it when an emergency arises with the minor child/ren that is in their care.

_____The resource caregiver agrees to notify the agency of any changes in their financial/ employment situation, criminal activity/history, and/or household composition within two (2) business days.

_____The resource caregiver agrees to cooperate with any SWAN Services if they are referred.

_____Family Pathways shall give written notice to resource families of its decision to approve, disapprove or provisionally approve the resource family. The written notice shall inform the resource parents that they may appeal the Agency's decision to disapprove or provisionally approve the resource family.

_____The resource family agrees to provide thirty days written notice to Family Pathways in the event they would like the child in their care removed from their home.

_____
Resource Caregiver's Signature
Date:_____

_____
Parenting Partner's Signature
Date:_____

_____
Coordinator/Facilitator's Signature
Date:_____

Family Pathways

Striving to Strengthen Relationships

WATER SAFETY POLICY

☐ Own a swimming pool ☐ Have access to a swimming pool

- Caregivers must use prudent judgment and ensure children in their care are protected from unsupervised access to water such as a swimming pool, hot tub, fountain, pond, lake, creek, or other body of water.
- Rules governing the activity and the dangers of the body of water must be explained to foster children in a manner that is clearly understood prior to their participation.
- Never permit the child in care to swim alone or be unsupervised near bodies of water.
- Completely fence the pool or ensure you follow local ordinance guidelines.
- Position latches and locks out of reach of young children.
- Keep all doors and windows leading to the pool area secure to prevent small children access to the pool.
- Do not use flotation devices as a substitute for supervision.
- Remove ladder if applicable

****Resource Caregivers are responsible for the safety of the child/ren in their care around swimming pools and/or bodies of water.**

_____
Resource Caregiver's Signature
Date:_____

_____
Parenting Partner's Signature
Date:_____

_____
Coordinator/Facilitator's Signature
Date:_____

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MEDICALLY FRAGILE SUPPORT

Family Pathways has identified additional support available to resource families who are caring for the special needs population. The child currently in your care was identified as a potential candidate for this additional support. The supplemental support levels vary per child and are child specific. To receive this funding the caregiver will have additional responsibilities designed to address these special needs. Therefore, prior to applying for these funds it is important that the caregiver agrees to provide the additional care (i.e. dietary needs, additional transportation, medical supplies (for example: eye glasses), additional trainings, or other needs as identified).

Another important fact that must be noted is that these funds are to be used solely for the benefit of the child in your care. These financial resources may not be disbursed to any other individual/family member. **This funding is subject to modification as eligibility and availability may change as determined by the child's physician.**

Your signature indicates that you understand the information outlined above and are interested in working with Family Pathways to explore this resource and commit to the expanded caregiver responsibilities.

If a resource family fails to provide these services, Family Pathways reserves the right to retain this additional funding to ensure the child's special needs are met.

_____

Resource Caregiver's Signature

Date:_____

_____

Parenting Partner's Signature

Date:_____

_____

Coordinator/Facilitator's Signature

Date:_____

Family Pathways

Striving to Strengthen Relationships

SAFETY MANDATE

Safety of children is of paramount importance. The transporting caregiver agrees to supervise the child/ren in the lobby of Family Pathways at all times during transition to appointments/ visits. We also agree to accompany the child/ren to the restroom during this time.

The transporting caregiver is responsible to monitor/supervise the child/ren in the presence of his/her birth family before and after appointment times.

It merits noting that as the resource caregiver, you are responsible for the safety of the child/ren while they under your watch and will make decisions accordingly.

_____ _____

Resource Caregiver's Signature
Date:_____

Parenting Partner's Signature
Date:_____

_____

Coordinator/Facilitator's Signature
Date:_____

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DOG LICENSE and RABIES VACCINATION POLICY

I understand that any dog, age three months or older, housed inside or outside the resource family residence, must be licensed yearly (or have a lifetime dog license) and have the appropriate rabies vaccination.

I further understand that any cat, age three months or older housed inside or outside the resource family residence, must have the appropriate rabies vaccination.

This policy is in accordance with Pennsylvania Code and Statute. By signing below, I acknowledge that if there is an incident involving a pet in our home, we will be required by law to submit verification of the dog license and rabies vaccination record for that pet and will assume any liability.

_____
Resource Caregiver's Signature
Date: _____

_____
Parenting Partner's Signature
Date: _____

_____
Coordinator/Facilitator's Signature
Date: _____