

Baptist Children's Home

Child Care Application Instructions:

Please complete the child care application as thoroughly as possible, along with the supplemental forms.

Attachments should include:

- Grade Reports
- Wage Earner Documentation
- Recent Picture

Mail or fax the completed application and forms to the Baptist Children's Home office nearest you or with whom you have been in contact:

Baptist Children's Home
354 West Street, Ste. 1
Valparaiso, IN 46383
219.462.4111
501.631.9169 (fax)

or

Baptist Children's Home
214 N. Mill Street
St. Louis, MI 48880
989.681.2171
989.488.1430 (fax)

After receiving the application, Baptist Children's Home staff will review it and determine the availability and possibility of placement. This process usually takes 3-4 days.

Interview

The next step in the application process is a personal interview conducted at the Baptist Children's Home office or group home. In some circumstances, when distance prohibits an on-site interview, a telephone interview may be conducted.

The purpose of the interview is to gather additional pertinent information, to answer any questions you may have and to familiarize the child and you with Baptist Children's Home. During the interview the child may have an opportunity to visit the group home and school.

The interview will be scheduled through the BCH office. The interview process usually takes two to three hours.

Notification

After the interview, the Baptist Children's Home staff will further review the information to determine if placement will be appropriate.

Within 3-4 days following the interview, the Baptist Children's Home will notify the parent/guardian about the acceptance of the child.

If your child is accepted for placement the following is required (as applicable):

- a. Original birth certificate or immigration paperwork (I-94)
- b. Child's Social Security card (original)
- c. Parents' Divorce Decree
- d. Guardianship/custody papers
- e. Adoption Decree
- f. Reports from medical specialists, psychiatrists, psychologists
- g. Physical Exam (within 3 months of placement) (must include vision and hearing screenings)
- h. Dental Exam (within 6 months prior to admission)
- i. Mantoux TB skin test (negative) or chest X-ray

All applicable items must be on file at time of placement. The child's family case manager will discuss with the family what other items to bring at placement.

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Return application by mail or fax:
 Indiana/Other 501.631.9169
 Michigan 989.488.1430

Please attach a photo of child

CHILD CARE APPLICATION

CHILD'S INFORMATION				Today's Date:	
Child's Name			Sex	Race	
DOB	Place of Birth	Age	Social Security #		
Street Address			City	State	Zip
County	Home Phone () ()	Work Phone () ()	Cell Phone () ()	Other Phone () ()	
Adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No Age at adoption: _____					
PHYSICAL CHARACTERISTICS					
Height	Weight	Hair Color	Eye Color	Identifying Marks	
School Attending					Grade
Religion		Church			
PARENT/GUARDIAN					
Guardian Name			Relationship		
Street Address		City	State	Zip	Phone () ()
REQUESTOR					
Requestor of Service		Email	Relationship		
Street Address		City	State	Zip	Phone () ()
REFERRAL					
Referral Source <input type="checkbox"/> Web <input type="checkbox"/> Church <input type="checkbox"/> Friend <input type="checkbox"/> Other _____					
Street Address		City	State	Zip	Phone () ()

Our Mission:

To Provide Christian Care and Counseling for Family Living

Child's Name _____

HISTORY

Presenting problems (Why are you seeking placement?)

Indicate which of the following apply to your child:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Failing Grades | <input type="checkbox"/> Sexually Abused |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Family Abuse |
| <input type="checkbox"/> Stealing | <input type="checkbox"/> Use of Tobacco | <input type="checkbox"/> History of Neglect |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Incurable |
| <input type="checkbox"/> Arrested | <input type="checkbox"/> Destructive Behavior | <input type="checkbox"/> Born out-of-wedlock |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Physical Aggressiveness | |
| <input type="checkbox"/> Profanity | <input type="checkbox"/> Suicidal Actions/Attempts | |
| <input type="checkbox"/> Runaway | <input type="checkbox"/> Received Special School Services | |
| <input type="checkbox"/> Bed-Wetting | <input type="checkbox"/> For Grades <input type="checkbox"/> For Behavior | |

Explain those areas checked or other concerns:

Indicate other Agencies/Services involved:

- | | | |
|--|---|---|
| <input type="checkbox"/> Court | <input type="checkbox"/> Probation | <input type="checkbox"/> Counselor/School Counselor |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Therapist |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Mental Health Agency | <input type="checkbox"/> Other |

Describe those areas checked:

Describe Your Child's Strengths

Please complete all sections and attachments before returning this application.

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Child's Name _____

FAMILY INFORMATION

INFORMATION ON PARENTS		
	Father	Mother
Full Name		
Address		
City/State/Zip		
Living?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Parental Health Status		
Phone		
Email Address		
Date of Birth		
Place of Birth		
Current Marital Status		
Marriage Date		
Divorce Date		
Separated? Date		
Date of Remarriage		
Occupation		
Employer		
Step-Parent Information		
Full Name		
Full Name		

SIBLINGS (include Step & Half Siblings) (attach additional pages if needed)			
Name	Birth Date	Address	Parents

Additional Close Relatives					
Name			Relationship		
Street Address	City	State	Zip	Phone	()
Name			Relationship		
Street Address	City	State	Zip	Phone	()

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Child's Name _____

CHURCH INFORMATION

Church			Pastor	
Street Address	City	State	Zip	Phone ()
Frequency of Church Attendance:				
Father	_____ Weekly	_____ Monthly	_____ Occasionally	_____ Never
Mother	_____ Weekly	_____ Monthly	_____ Occasionally	_____ Never
Child	_____ Weekly	_____ Monthly	_____ Occasionally	_____ Never
Have you received counsel from your church?			Yes/No _____	
Explain _____				

SCHOOL INFORMATION

School Name				
Street Address	City	State	Zip	Phone ()
Grade 1 2 3 4 5 6 7 8 9 10 11 12			Grades Retained	
Is Child Enrolled in Special Education Programs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Explain

SCHOOL ACCOMPLISHMENTS (Please attach a Current Report Card)

Explain suspensions or expulsions _____

SCHOOL HISTORY

School Name	Address/City/State/Zip	Grade Attended	Year	Grades

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Child's Name _____

FINANCIAL

Indicate the Monthly Household income: \$ _____

Wage Earner Name	Monthly Income*

**If accepted, we will request proof of wage such as current pay stub or W-2.*

Do you or your child receive Social Security benefits? Parent: Yes No Amount per month: \$ _____
 Child: Yes No Amount per month: \$ _____

Do you receive any other type of government aid? Please describe: _____

An individual's ability to pay program fees is discussed during the interview. Monetary restrictions will not hinder an eligible applicant.

Please indicate how you plan to meet the cost of services:

INSURANCE

Medical Insurance Coverage

Company	Policy Number	Group Number	Contact Number	Insured Name



As the parent/guardian of _____, I understand that, if my child is accepted into care with Baptist Children's Home & Family Ministries, I am responsible for:

- Monthly Fees for the care of my child
- Medical, Dental, Vision, and Emergency Care
- Transportation of my child during holidays, breaks and family visits

 Parent Signature

 Date

 Printed Name

 Relationship to child

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Child's Name _____

MEDICAL INFORMATION AND HISTORY

Name of Hospital where born			
Street Address	City	State	Zip

Check all that apply to your child

- | | |
|---|---|
| <input type="checkbox"/> Measles
<input type="checkbox"/> German Measles
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Mumps
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies (describe below)
<input type="checkbox"/> Asthma (describe below)
<input type="checkbox"/> Diabetes (describe below)
<input type="checkbox"/> Sickle Cell (indicate current below)
<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Hearing Impairments
<input type="checkbox"/> Vision Impairments
<input type="checkbox"/> Other _____ |
|---|---|

Explain _____

Family Medical History: Indicate any of the following that have been experienced in the family

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> T.B.
<input type="checkbox"/> Syphilis
<input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer
<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Mental Illness | <input type="checkbox"/> Birth Defects
<input type="checkbox"/> Degenerative Diseases
<input type="checkbox"/> HIV Infection | <input type="checkbox"/> Epilepsy
<input type="checkbox"/> Allergies
<input type="checkbox"/> Other |
|---|---|--|---|

Explain _____

In the last year has your child been to the: Doctor: Yes No Dentist: Yes No

Describe any cultural or ethnic background that may have a bearing on the child's development or behavior:

CURRENT MEDICATIONS/PRESCRIPTIONS (Use additional sheet if needed)

Medication Name	Dose	Reason	Doctor	Expiration

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OTHER RELEVANT PROFESSIONALS

Physician

Physicians Name				
Street Address	City	State	Zip	Phone ()
Comments				

Dentist

Dentist Name				
Street Address	City	State	Zip	Phone ()
Comments				

Optometrist

Optometrist Name				
Street Address	City	State	Zip	Phone ()
Comments				

Orthodontist

Orthodontist Name				
Street Address	City	State	Zip	Phone ()
Comments				

Counselor

Counselor Name				
Street Address	City	State	Zip	Phone ()
Comments				

Caseworker

Caseworker Name				
Street Address	City	State	Zip	Phone ()
Comments				

Specialist

Specialist Name				
Street Address	City	State	Zip	Phone ()
Comments				

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Child's Name _____

**CHILDCARE
 ADDITIONAL INFORMATION SHEET**

List those individuals you approve to visit, call, write, or email your child. Indicate any limitations you desire.

NAME	ADDRESS	PHONE	RELATION	LIMITATION & REASON

History of child's residences from birth.

Address	Dates	With Whom

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RELEASE OF INFORMATION

I, _____ give the Baptist Children's Home
(Parent/Guardian)

permission to receive information regarding my child, _____

D.O.B. _____. I understand that any information exchanged

will be used for professional purposes only and will be held confidential.

Signature

Date