ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

BACKGROUND FOR DEPARTMENT RECOMMENDATION ON CUSTODY

(1017 or Article 6)

478 Main Street, Buffalo, New York 14202

Date of Placement: _____

Primary Caretaker

Name:	
Date of Birth:	Race:
Address (Street, City/Town, County, State, Zip):	
Daytime Phone Number:	
Home Phone Number:	
Email:	

Secondary Caretaker

Name:	
Date of Birth:	Race:
Address (Street, City/Town, County, State, Zip):	
Daytime Phone Number:	
Home Phone Number:	
Email:	

CHILD CHARACTERISTICS

1. **Name of the children to be potentially placed in home:**

Child 1:

Name:		Sex:	Male ◯ Female ◯	Age	

Child 2:

Name:		Sex:	Male ◯ Female ◯	Age	

Child 3:

Name:		Sex:	Male ◯ Female ◯	Age	

Child 4:

Name:		Sex:	Male ◯ Female ◯	Age	

2. Are you aware of any of the following special needs of the child(ren) you are considering caring for in your home?

	Mild	Moderate	Severe
Physical			
Mental Health			
Developmental Disability			
Emotional/Behavioral			
Learning			

3. The following special needs have been identified at this time:

4. Your reasons for wanting to care for this child in your home:

5. Your relationship to the child:

Grandparent ☐
Godparent ☐
Uncle ☐
Aunt ☐
Cousin ☐
Family Friend ☐
Other ☐

If selected Other, please provide details in the space below:

6. **Have you taken care of children other than your own in your own home?**
   Yes ☐ No ☐

If so, please provide some general information regarding this care:

Sex:	Male ◯ Female ◯	Child Age		Length of time spent in your care	
Received from whom?					
Reason for leaving?					

7. **Do you feel you are able to meet the ongoing needs of the child (eg. behavioral, religious, cultural, developmental)?**
   Yes ☐ No ☐

CARETAKER INFORMATION

Please list below and complete the requested information about all others living in your home:

Name of children living in your home	**Sex**	**DOB**

Name of other people living in your home (Indicate if related to caretaker and how related)	**Sex**	**DOB**

Name of your children living outside your home	**Sex**	**DOB**

EMPLOYMENT/SOURCE OF INCOME

Primary Caretaker:

Current Profession or Trade					
Name of Employer					
Address					
Phone Number					
Hours Per Week		**Yearly Salary**		**Length of Employment (in years)**	
Alternate Source of Income (For example, SSI, SSD, Public Assistance or Alimony)					

Secondary Caretaker:

Current Profession or Trade					
Name of Employer					
Address					
Phone Number					
Hours Per Week		**Yearly Salary**		**Length of Employment (in years)**	
Alternate Source of Income (For example, SSI, SSD, Public Assistance or Alimony)					

Child Care Plan

- Before School Care Needed ☐
- After School Care Needed ☐
- Full Time Day Care Needed ☐
- Part Time Day Care Needed ☐
- None - all basic needs of the child(ren) will be met without assistance ☐

Challenges to providing care/resources needed:
(Please select ALL that apply)

Financial Assistance	☐
Transportation	☐
Car Seats	☐
Furniture	☐
Medical Insurance/Medicaid	☐
Clothing	☐
Food Stamps	☐
Other	☐

If selected Other, please provide details in the space below

PERSONAL INFORMATION

1. **How will the child's placement affect the parent/child/caregiver relationship?**

2. **Will the alleged perpetrator of child abuse/neglect have access to the child in your home?**

Yes ☐ No ☐

If yes, how will you control the alleged perpetrators access?

3. **Is placement in your home close proximity to the child's parent(s) for reunification purposes and when possible close to the child's current school placement?**

Yes ☐ No ☐

4. **Are there any other factors that may prevent you from being able to care for the child, such as, commitments outside the home and number of persons already dependent upon the caregiver?**

   Yes ☐ No ☐

   a. **Does your age, physical and mental health allow you to adequately care for the child?**

      Yes ☐ No ☐

   b. **Are you or any member of your household on any type of prescribed drugs?**

      Yes ☐ No ☐

Patients Name	
Name of Drug	
Reason Prescribed	

   c. **Do you or any member of your household have any physical problems?**

      Yes ☐ No ☐

Patients Name	
Please provide details of physical problem(s)	

   d. **Do you or any members of your household have any mental health problems and/or have ever attended counselling?**

      Yes ☐ No ☐

Place of Treatment	
Date	
Was this treatment with your family physician or was it at a general clinic?	Family Physician ☐ General Clinic ☐

5. **Please provide the following information about your family physician(s)**

Name	
Phone	
Address	

Name	
Phone	
Address	

6. **Have you or any member of your family ever received foster care services from any other social agency, public or private, within this area or out of state?**

   Yes ☐ No ☐

If yes, please explain?

7. **Have you, any member of your household, or anyone who may assist with child care, ever been the subject of an Indicated Child Abuse/Maltreatment Report?**

   Yes ☐ No ☐

If yes, please provide details below

State	
Country	
Date	

8. **Have you ever applied to any other agency for an adoption/foster care home study?**

   Yes ☐ No ☐

If so, which agency

9. **Have you, any other member of your household, or anyone who may assist with child care, ever had a criminal conviction, have current charges pending and/or been placed on probation?**

   Yes ☐ No ☐

If YES, please explain and identify the family members that have previous or current criminal activities

If YES, do you understand that you must provide our agency with a copy of this conviction record?

Yes ☐ No ☐

10. **Do you have any adults that frequent the home who have been the subject of an Indicated Child Abuse/Maltreatment Report or have criminal convictions or current charges pending?**
    Yes ☐ No ☐

11. **How long have you lived at you current address?** ☐

12. **Where else have you lived in the past 5 years?**

13. **Are you willing to accept the county agency involvement and work cooperatively with the county agency?**
    Yes ☐ No ☐

ASSESSMENT OF THE HOME

1. At least one flush toilet, one sink and one bath or shower with hot and cold running water?	☐
2. An operable heating and electrical system?	☐
3. Food storage and cooking facilities?	☐
4. Adequate sleeping area (not a hallway, garage, closet, common area, etc.) and child has a clean, comfortable mattress with clean linens?	☐
5. Caretaker(s) have appropriate, up to date car seats for children 8 years of age and under?	☐
6. Does the home have smoke detectors and carbon monoxide detectors?	☐
Additional Comments	

ACKNOWLEDGEMENT

The facts set forth in this document are true and complete. I agree to cooperate with ECDSS in supplying or assisting in gathering any necessary materials as required to complete this document.

Signatures

Primary Caretaker:	Date:
Secondary Caretaker:	Date: