Washington State Department of CHILDREN, YOUTH & FAMILIES

LICENSING DIVISION (LD)

Application for Certified Respite Provider

☐ State ☐ CPA

The care is to be provided only in a licensed foster home.

Applicant Information				
NAME (IF ANY) (LIST IN FULL)	FIRST NAME	MIDDLE NAME (IF ANY)	LAST NAME	SUFFIX
PREFERRED NAME (IF ANY) (LIST IN FULL)	FIRST NAME	MIDDLE NAME (IF ANY)	LAST NAME	SUFFIX
FORMER NAMES, NICKNAMES, OTHER NAMES YOU HAVE GONE BY (IF ANY) (LIST IN FULL)	FIRST NAME	MIDDLE NAME (IF ANY)	LAST NAME	SUFFIX
	FIRST NAME	MIDDLE NAME (IF ANY)	LAST NAME	SUFFIX
	FIRST NAME	MIDDLE NAME (IF ANY)	LAST NAME	SUFFIX
WHAT IS YOUR:	GENDER IDENTITY ☐ Female ☐ Male ☐ X	BIRTHDATE	SOCIAL SECURITY NUMBER	
	PHONE NUMBER	EMAIL	PREFERRED CONTACT ☐ Phone ☐ Text ☐ Email ☐ Postal Mail	
STREET ADDRESS	STREET ADDRESS	CITY STATE ,	ZIP CODE (+4 OPTIONAL)	COUNTY
MAILING ADDRESS (IF DIFFERENT)	STREET ADDRESS	CITY STATE ,	ZIP CODE (+4 OPTIONAL)	COUNTY
LANGUAGES IN WHICH YOU CAN COMMUNICATE WITH A CHILD	PRIMARY	ADDITIONAL		

Type of Care

Once you are certified as a respite provider, you are approved to provide support in any licensed foster home.
I am willing to provide respite support to:

- ☐ General foster homes
- ☐ A specific home
- ☐ Both

NAME OF SPECIFIC FOSTER HOME WHERE YOU WILL PROVIDE RESPITE CARE (IF APPLICABLE)

STREET ADDRESS	CITY , WA	ZIP CODE (+4 OPTIONAL)	COUNTY

Background

Have you ever been told that you have a problem with any of the following: (pick all that apply)

- ☐ Alcohol (Please Describe):
- ☐ Marijuana (Please Describe):
- ☐ Illegal drugs (Please Describe):
- ☐ Mental Health (Please Describe):
- ☐ Prescription drugs (Please Describe):
- ☐ Anger management (Please Describe):
- ☐ N/A
- ☐ Prefer to discuss in person

Have you had a serious injury, illness, or hospitalization during the past year? (pick one)

- ☐ Yes (Please Describe):
- ☐ No
- ☐ Prefer to discuss in person

Have you had a history of mental or physical limitations? (pick one)

- ☐ Yes (Please Describe):
- ☐ No
- ☐ Prefer to discuss in person

Are you currently taking medication that will affect your ability to care for a child? (pick one)

- ☐ Yes (Please Describe):
- ☐ No
- ☐ Prefer to discuss in person

Character References

NAME (FIRST AND LAST)	EMAIL	TELEPHONE NUMBER (INCLUDE AREA CODE)	RELATIONSHIP TO APPLICANT	MAILING ADDRESS INCLUDING ZIP CODE (IF NO EMAIL ADDRESS)

I give permission to DCYF to contact references listed in this application and to discuss issues relevant to my application.

I understand that DCYF will do a criminal history record check and a check for files regarding abuse and neglect.

I certify that the above information and required attachments are true and complete to the best of my knowledge.

I understand that failure to truthfully disclose all relevant information may be grounds for denial of this Application for Certified Respite Provider.

SIGNATURE DATE