Dear Parent,

We are here to help you through this difficult time. Host Families are people who willingly and without pay open their homes to a child of a parent who is going through a difficult time. We would like to offer this to you. In addition, a Safe Family volunteer Family Coach will help you during this time to provide support, encouragement, and resources. Our volunteers live throughout the region, and they have all been screened and approved similar to foster care. These families take in children as young as newborns all the way through parenting teenagers. Children stay with a Safe Family as short as 1 night and as long as 6 months. Our average stay is between 30-45 days. Our families are only interested in helping short-term. We do not do adoptions. They would like to help and be a support to you. Parents who have their children hosted have had similar problems to what you are struggling with (homelessness, being overwhelmed, depression, health problems, drugs, etc.).

It is important to know that this is not foster care, and if you have your children hosted, you are not placing them with the State Department of Children and Family Services (DCFS). Instead, we are similar to having an aunt or uncle (informal support) and you are asking them to take care of your children while you get back on your feet. All children are returned to their parents, unless other arrangements are made.

In order to get started, we need you to fill out these forms. Please fill out pages 2-5 for each child. This gives the family who cares for your children the right to have them in their home and to make medical decisions in an emergency when we can’t reach you. It also tells them some information about your children that may be very important for them to know. The parent information form will be used by your Family Coach to understand the current challenges you are facing and to determine what local resources may help. Once a family is found, we will make arrangements to have your kids brought to their home. We would like for you to meet them, if that can be arranged.

Other things you should know:

1. You can change your mind at any time and have your children returned to you. If you have a DCFS worker, they would also need to participate in that decision.
2. **Visits** – We strongly encourage you visiting your children. Our staff will help with visits and we try to do it at a time and place that is convenient to you and the Safe Family.
3. **Phone Calls** – If your child is old enough, we encourage phone calls. These can occur daily, if you like, as long as it is not too inconvenient for both you and the Safe Family.
4. **Family Coach** - You will need to stay in contact with your family coach weekly in order for us to best help you during this time. If any important information changes (ex. phone number) please call your coach as soon as possible to update your information.
5. **Contacting us** – You can contact us anytime you want. You can reach our main office at 773-653-2200.

I hope you will consider Safe Families for your children. Our Family Coaches will do what they can to help you get back on your feet during placement. Call us anytime.

Sincerely,

Safe Families for Children
Parental Consent for Participation in Safe Families for Children with Appointment of Short-Term Legal Guardian and Power of Attorney for Health Care of a Minor Dependent

Dear _______________________________ (Host Family),

Thank you so much for being willing to care for my child ___________________________. His/her date of birth is _______________. I, __________________________, residing at ______________________________________, am the custodial parent of this child and am giving permission for you to care for him/her (short-term guardian, temporary custodian) beginning __________________ (date to start). I should be ready to have my child back by ________________ (estimated end date—may not exceed 365 days) at which time this agreement will end unless I ask (and you are willing to) to allow this agreement to continue. I understand that I maintain full and complete custody of my child and am welcome to request my child back at any time.

With this agreement, I give you permission to:

- Administer prescription and non-prescription medication as medically required;
- Seek emergency and non-emergency medical care for my child on my behalf (be the power of attorney for health care). This includes routine medical visits, diagnostic evaluations, in-patient and outpatient hospitalizations, etc. My child’s insurance information is __________________ (insurer), ________________ (ID #). A copy of my insurance information is provided. I agree to be responsible for any medical costs that are not covered by my insurance.
- Discipline my child in a firm and consistent manner, utilizing individual talks, removal of privileges, or any other non-physical punishment appropriate for his/her developmental level. Spanking or any other forms of physical punishment are not allowed.
- I authorize LYDIA home Association/ Safe Families staff to communicate (receive & Exchange information) with (Safe Family parent(s) named above) and any service providers I am involved with confidential information for the purpose of coordinating and optimizing the services provided to me and my child(ren). _______ (initials)
- I understand that I am responsible to update my family coach as soon as possible with any important changes including phone number, address, and any new information about my situation. _______ (initials)

OPTIONAL ITEMS:

- You may take a picture of my child for publication purposes _______ (initials)
- You may take my child out of state on a trip or vacation with notification when this happens _______ (initials)

I pledge to use this time to make the necessary changes in order to be in a better position to care for my child. This specifically refers to situations that led me to need for my child to stay with you.

I acknowledge that you are offering this service to me out of a spirit of generosity and compassion and that you are not being paid for this act of kindness. Because I know that accidents happen even when adults are vigilant, I also agree, on behalf of myself, ________________ (child’s name), and the rest of my family, that none of us will hold you, __________________________ (Host Family), or the sponsoring agency, Lydia Home, responsible for any accidental injuries or losses of any kind that we may suffer or incur as a result of our family’s participation or involvement in the Safe Families for Children program or the stay in your home. I understand that you cannot guarantee the safety of my child. I agree to assume any risks with my child staying in your home. Finally, I acknowledge that my child is staying in your home as a guest and not as a tenant or resident. My child and I would have to leave your home at any time that you request. I also
understand that my child might have to go live with another Host Family in the event you are no longer able to care for him/her. Please let me know when that occurs.

My signature affirms my agreement with all the statements above except the optional items I can choose to opt in or not.

Emergency Contact(s)/Authorized individuals for pick up
These following individuals (other than parents or guardians) are willing to accept responsibility for the child and should be contacted if the parents or guardians cannot be reached.

Name________________________________________________Relationship________________________________________

Phone____________________________________________________Address___________________________________________

____________________________________________________________________________________

Appointing Parent/Guardian Signature              Consenting Parent Signature
*If there is not a second parent signing, please indicate why

Date

Witnesses. Two witnesses need to sign this document. I saw the parent (or guardian) sign this document. Then I signed this as a witness in the presence of the parent. I am not appointed in this document as the short-term guardian.

Witness 1

Date

Witness 2

Date

I accept temporary guardianship of _____________________________ (child) and will abide by this agreement.

Host Family Signature              Date

*(Note: the signature of the consenting parent is not necessary if one of the following applies: (i) the child’s other parent has died; or (ii) the whereabouts of the child’s other parent are not known; or (iii) the child’s other parent is not willing or able to make and carry out day-to-day child care decisions concerning the child; or (iv) the child’s parents were never married and no court order has issued an order establishing parentage)

CHILD INFORMATION FORM

Information provided by: ______________________________________________________
Date of completion: _________________________________________________________

Child’s name _______________________________ Nickname: ___________________________ d.o.b. ____/____/____

Mother’s name/address: ________________________________________________________
Father’s name/address: _________________________________________________________
Legal guardian(s) (if not parents) __________________________________ Phone ____________________
Address ____________________________________________________ City/State/ZIP _____________
In case of emergency, who should be notified first? □ Mother □ Father □ Other ________________
Languages spoken in the home: ___________________________ Race/Ethnicity ______________________

What does your child like to do for fun? ______________________________________________________________
_________________________________________________________________________________________________

What are your child’s favorite foods? ________________________________________________________________
_________________________________________________________________________________________________
What situations, relationships, or events tend to be hardest, upsetting or fearful for this child?
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Discipline/Training at our home includes:

□ time-outs □ talking about
behavior □ rewards / loss of
privileges □ spanking □
other __________

When does your child wake up?
___________ When is naptime?
___________ When is bedtime?

HEALTH RELATED QUESTIONS. If you answer “yes,” use the space provided to explain.

Child’s physician name/address/telephone:_____________________________________________________________
Describe type and location of birthmarks:_____________________________________________________________
Chronic/ongoing health problems? □ Yes □ No
Has your child ever had any breathing problems or been diagnosed with asthma? □ No □ Yes
Current Medications:_____________________________________________________________________________
Does your child have any allergies? □ No □ Yes:
Has your child had any unusual illnesses or injuries? □ No □ Yes:
Does your child receive outpatient services from any social service agency or medical provider? □ No □ Yes:_______
Does your child have any current health related issues that require attention (vaccinations out of date, etc.)

□ No □ Yes: _____________________________________________________________

EDUCATION RELATED QUESTIONS. If child is not attending a program, skip to the next section.

School or Early Childhood Program location/address: ______________________________________________________
__________________________________________________________________________________________________
Grade: ___________________ Teacher’s name: _________________________________________________________________
Transportation to school: ___________________ School program hours: ___________________
Before and/or After School Programs: _________________________________________________________________
Before and/or After School Programs times: ___________________________________________________________
Does your child have academic or behavioral difficulties at school that require a special education (IEP) or discipline plan?
□ No □ Yes:

INFANTS/TODDLERS INFORMATION. If your child is older, skip to next section.

Is your child potty trained during waking hours? □ Yes □ No  Does your child stay dry overnight? □ Yes □ No
Diaper brand/type and size: _________________________________________________________________
What words does your child use when he/she needs to use the toilet? _____________________________
What type of formula and bottle does your child use? _____________________________________________
Table foods your child eats: _________________________________________________________________
What is your child’s bedtime/nap routine? _____________________________________________________
__________________________________________________________________________________________
Are there any problems associated with bedtime/nap?

Please check all that apply to your child:

□ Depressed  □ Overactive  □ Nightmares  □ Runs away
□ Anxious  □ Easily frustrated  □ Sleep difficulties  □ Mental Health Issues
□ Fearful  □ Peer problems  □ Eating difficulties  □ Uses drugs/alcohol
□ Withdrawn  □ School problems  □ Wets bed  □ Skips School
□ Low self-esteem  □ Sexualized behavior  □ Temper tantrums  □ Hurts him/herself
□ Poorly motivated  □ Aggressive toward others  □ Daydreams  □ Steals
Is there anything else that you would like our volunteers to know about your child to best care for him/her?

_________________________________________________________________________________________________

_________________________________________________________________________________________________

PARENT INFORMATION FORM

Date of completion: _____________________

GENERAL INFORMATION

Your name:_________________________________________ d.o.b.______/______/______
Address_________________________________________ City/State/ZIP_________________
Phone Number: __________________ Alternate phone:_______________ Email:__________

Second Parent Name:_____________________________ d.o.b.______/______/______
Address_________________________________________ City/State/ZIP_________________
Phone Number: __________________ Alternate phone:_______________ Email:__________

Marital status: □ Married    □ Separated    □ Divorced    □ Cohabitation    □ Single Parent

Children:

Name_________________________________________ Age______ M/F ______ Grade______
Name_________________________________________ Age______ M/F ______ Grade______
Name_________________________________________ Age______ M/F ______ Grade______
Name_________________________________________ Age______ M/F ______ Grade______

EDUCATION/WORK EXPERIENCE

Highest level of schooling completed: □ GED □ HS Diploma □ Some College □ College/Trade School
Specialized training or certificate? ______________________________________________________________________
Employer_________________________________________ Occupation___________________
Work Address/ Phone:________________________________________________________________________________
Previous work experience:_____________________________________________________________________________

MEDICAL INFORMATION. If you answer “yes,” use the space provided to explain.

Significant Illnesses/Chronic Health Problems:____________________________________________________________
Prescribed Medication:_________________________________________________________________________________
Do you have any health concerns that need attention? □ No  Yes: ____________________________________________
Have you ever received counseling/treatment for drugs or alcohol addiction?
□ Yes □ No
If “yes”, please provide dates, location & treatment received: ____________________________________________________________________________________________________________________________
Have you ever received treatment in a psychiatric hospital or outpatient mental health center? □ Yes □ No
If “yes”, please provide dates, location & treatment received: ____________________________________________________________________________________________________________________________
Do you suffer from any of the following conditions? (Please check)
□ Anxiety □ Post Traumatic Stress Disorder □ Depression □ Other __________________________
□ Physical Abuse □ Sexual Abuse □ Domestic Violence □ Rape □ Homelessness
□ Drug Abuse □ Alcohol Abuse □ Financial Problems □ Suicidal Thoughts
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________

NEEDS/GOALS/STRENGTHS

What is your reason for seeking temporary care for your child(ren) with Safe Families?
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
What are your primary goals to attain to be able to bring your child back into a healthy, stable home environment?
Goal 1: ____________________________________________ Goal 2: ____________________________________________
Goal 3: ____________________________________________ Goal 4: ____________________________________________
What personal attributes, strengths or resources do you have that will be helpful in achieving this/these goals?
______________________________________________________________________________________________________________________________________________________________________________________________________________________________

SOCIAL SUPPORT INFORMATION. If you answer “yes,” use the space provided to explain.
Have you ever been involved with DFCS? □ Yes □ No If “yes”, please provide dates, situation and services received:
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
Have you ever been charged with a crime? □ Yes □ No If “yes”, for what:
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
Which public assistance do you or have you received? □ WIC □ TANF □ LINK □ SSI □ Childcare □ Other:
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
Are you receiving support services from any other agencies? □ Yes □ No If “yes”, please provide the following:
Agency: _____________________ Case Worker Name: _____________________ Phone number: ____________
List names and type of relationship for any extended family members, close friends, or neighbors nearby that are a support to you:
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________________________________________________________________________
I have these needs/would like referrals for the following (Please Check):
□ Employment □ Housing □ Education □ Donations/Supplies
□ Counseling □ Marriage Counseling □ Personal support/mentor □ Drug Treatment
- Learn Parenting Skills
- Respite/babysitting
- Daycare/Headstart
- Transportation
- Spiritual Support
- Meals/Food
- Reading/literacy/tutoring
- Community Support
- Legal Assistance
- Financial Assistance
- Medical Assistance
- Cleaning/Organizing Home

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