



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<sup>[1]</sup> and Power of Attorney for  
Health Care of a Minor Dependent<sup>[2]</sup>

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

\_\_\_\_\_  
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

\_\_\_\_\_  
Consenting Parent Signature

\*If there is not a second parent signing, please indicate why

\_\_\_\_\_  
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)

[1] Pursuant to 755 ILCS 5/11-5.4, [1] Pursuant to 755 ILCS 45/4-1 et seq.

## 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?  No  Yes:

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/naps? \_\_\_\_\_

**Please check all that apply to your child:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Depressed        | <input type="checkbox"/> Overactive               | <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Runs away            |
| <input type="checkbox"/> Anxious          | <input type="checkbox"/> Easily frustrated        | <input type="checkbox"/> Sleep difficulties  | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Fearful          | <input type="checkbox"/> Peer problems            | <input type="checkbox"/> Eating difficulties | <input type="checkbox"/> Uses drugs/alcohol   |
| <input type="checkbox"/> Withdrawn        | <input type="checkbox"/> School problems          | <input type="checkbox"/> Wets bed            | <input type="checkbox"/> Skips School         |
| <input type="checkbox"/> Low self-esteem  | <input type="checkbox"/> Sexualized behavior      | <input type="checkbox"/> Temper tantrums     | <input type="checkbox"/> Hurts him/herself    |
| <input type="checkbox"/> Poorly motivated | <input type="checkbox"/> Aggressive toward others | <input type="checkbox"/> Daydreams           | <input type="checkbox"/> Steals               |

*Is there anything else that you would like our volunteers to know about your child to best care for him/her?*

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## 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 \_\_\_\_\_

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?  Yes  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 \_\_\_\_\_

I have had these experiences (Please Check):

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:*

Were you convicted?  Yes  No: *If "yes", what was your sentence?* \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Learn Parenting Skills    | <input type="checkbox"/> Respite/babysitting  | <input type="checkbox"/>                          |
| <input type="checkbox"/> Daycare/Headstart         | <input type="checkbox"/> Transportation       |   |
| <input type="checkbox"/> Spiritual Support         | <input type="checkbox"/> Meals/Food           | <input type="checkbox"/>                          |
| <input type="checkbox"/> Reading/literacy/tutoring | <input type="checkbox"/> Community Support    |   |
| <input type="checkbox"/> Legal Assistance          | <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Medical Assistance       |
|  |   | <input type="checkbox"/> Cleaning/Organizing Home |

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**Parent Signature**

**Date**