



# Foster Family Setting Health Assessment\*\*

Child Foster Care MN. RULE 2960.3060 SUBP. 3

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**The purpose of this form is to assess that you are physically able to care for foster children. This form will be used to identify any limitations you may have and to assist in the matching of children to your home.**

What is the date of your last physical examination? \_\_\_\_\_

**Do you now or have you in the past two (2) years:**

Taken medication on a daily basis? YES NO Will it affect your ability to provide care? YES NO

If yes, please describe: \_\_\_\_\_

Received care/been diagnosed by a health professional for ongoing physical health issues? YES NO

If yes, please describe: \_\_\_\_\_

Received care/been diagnosed by a mental health professional for mental health related issues? YES NO

If yes, please describe: \_\_\_\_\_

Do you have any disability, history, or present evidence of a serious operation or injury? YES NO

If yes, please describe: \_\_\_\_\_

Do you have any communicable diseases? YES NO

If yes, please describe: \_\_\_\_\_

Is there another physician with whom we should consult before making a decision about your application? YES NO

If yes, please provide name and contact information: \_\_\_\_\_

**To be completed by adult household members:**

2960.3010 Subp. 9. **Chemical.** "Chemical" means alcohol, solvents, and other mood altering substances, including controlled substances.

2960.3010 Subp. 10. **Chemical dependency.** "Chemical dependency" means a pattern of pathological use accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use.

**Do you now or have you in the past two (2) years:**

Received chemical dependency treatment or been diagnosed as chemically dependant? YES NO

If yes, please describe: \_\_\_\_\_

**Will you be able to accomplish the following (if needed)?**

- |     |    |                             |     |    |   |
|-----|----|-----------------------------|-----|----|---|
| YES | NO | Dress or assist in dressing | YES | NO | Bathe or assist in bathing              |
| YES | NO | Assist in grooming          | YES | NO | Assist in feeding                       |
| YES | NO | Turn/position child         | YES | NO | Transfer                                |
| YES | NO | Assist with wheeling        | YES | NO | Assist in toileting                     |
| YES | NO | Prepare meals               | YES | NO | Transport child (emergency evacuation)  |
| YES | NO | Assist child in/out of tub  | YES | NO | Redirect child in a dangerous situation |

In your own words, please provide a written statement below, indicating that you are receiving all necessary medical care and are physically able to care for children. Please include any physical or psychological limitations that you may have.

In your own words, please provide a written statement below, indicating that you have been free of chemical use problems for the past two years. Please include any chemical use issues you may have.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*This form must be completed by all applicants and household members. Minors may be assisted by guardian as necessary.\*\*

**A false statement knowingly made at the time of application is grounds to deny or revoke a license (Mn. 9543.0100, Subp. 3)**

***2960.3060 Subp 3 G***

*The licensing agency may consult with a specialist in such areas as health, mental health, or chemical dependency to evaluate the abilities of the applicant to provide a safe environment for foster children. The licensing agency and the specialist must evaluate each applicant individually. The licensing agency must request a release of information from the applicant prior to assigning the specialist to evaluate the applicant. The licensing agency must tell the applicant why it is using a specialist to evaluate the applicant.*