Indianapolis Regional Office
338 South Arlington #205
Indianapolis, IN 46219
317-352-9706
Fax: 317-352-9709
www.benchmarkfamilyservices.org

Foster Home Water Supply Conformation

As a potential foster parent(s), the type of water supply system for your home will need to be verified as an important part of the licensing process. Please review the following choices listed below and check the appropriate box. Be aware, if you are connected to a Well Water Supply System, you are ***required*** to have an initial Well Inspection / Analysis and annually there after, to verify the water supply is safe for normal / typical consumption and / or use. You can request a Well Water Inspection / Analysis by contacting your Local Health and / or Environmental Department. You may also use a private company that specializes in Well Water Inspection / Analysis.

☐ My Foster Home is connected to the City Water Supply System

☐ My Foster Home is connected to a Well Water Supply System

Foster Home Address: _____

_____

_____

_____

Signature of Foster Parent: _____ Date: _____ / _____ / _____

---

* Licensing Use Only *

☐ City Water Supply System Confirmed – No Further Action Required

☐ Well Inspection / Analysis Completed and Approved Date: _____ / _____ / _____

☐ Copy of Inspection / Analysis Results is on File / Attached to this Document

INSTRUCTIONS FOR WATER ANALYSIS

All foster family homes that are not serviced by city water and sewage must have the water supply approved through an analysis from the Indiana Department of Health. To obtain a water sample bottle(s), write directly to:

Water Laboratory
Indiana Department of Health
402 West Washington Street, Room W364
Indianapolis, IN 46202

To ensure that the sample bottle(s) is shipped without delay, specify the following items in your letter requesting a water bottle(s):

1. Specify the TYPE of bottle(s) desired (private drinking water).
2. Specify the NUMBER of bottle(s) desired.
3. Enclose a check or money order made payable to the Indiana Department of Health to cover the required testing mailing fee.
4. Include the complete mailing address where you wish the bottle(s) to be sent.

DIRECTIONS FOR TAKING WATER SAMPLES

Before sampling, a small white crystal or spot of powder may be visible in the bottle. This is sterilized sodium thiosulfate, provided to deactivate any chlorine present in the water sample. DO NOT try to rinse out this substance prior to sampling, or you will contaminate the bottle.

Choose a sampling point in the water distribution system where the water outlet receives reasonable protection and is not subject to splashing. Avoid frost-proof hydrants, fire plugs, drinking fountains, kitchen sinks or damaged or dripping outlets.

If the selected sampling or outlet is equipped with a screen, strainer, or aerator, remove this device before processing. Then, open valve completely; and let the water run to waste as rapidly as possible for at least five (5) minutes.

Next, turn the valve down until only a thin stream of water is running. Remove the sample bottle cap, being careful not to touch or contaminate the neck or cap of the bottle. Then, fill the bottle with water until it is at least two-thirds full while leaving room at the top for expansion. Avoid hand contact with the water stream as it enters the bottle. Replace the bottle cap, and secure it tightly.

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Firearm Conformation

As a potential foster parent(s), Benchmark wants to make sure that any and all firearms are clearly identified *AS PRESENT* in your home or that there are *NO* firearms in your home. We request that you confirm and verify this on this document, as this is a very important part of the licensing process. Please review the following choices listed below and check the appropriate box. Be aware that you are *REQUIRED* to *NOTIFY* Benchmark immediately of any changes regarding this matter.

☐ My Foster Home has Firearm(s)

☐ My Foster Home does not have any Firearm(s)

Foster Home Address: _____

_____

_____

_____

Signature of Foster Parent: _____ Date: _____ / _____ / _____

---

* Licensing Use Only *

☐ If Firearm(s) and Ammunition are Present in the Home, Unloaded Firearm(s) and Ammunition are Stored in Separate Locked Places

☐ Reviewed and Confirmed by the Licensing Specialists Date: _____ / _____ / _____

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Guidelines for the Emergency Forms

1. **Emergency Numbers and Disaster Plan**: All foster children who are placed in your home should be familiarized with the family plan should a disaster occur. Foster children should know where to meet outside your home if it is damaged and where safe places are located in and outside of your community.

2. **Evacuation Plan:** The evacuation plan should consist of a detailed and accurate drawing of the layout of each floor in your home. Please include labels for each room with indicated primary and secondary escape routes.

* Both plans need to hang in a centralized location, such as the kitchen refrigerator and be accessible at all times.

** Copies of these plans are required for your Benchmark Family Services file and must be turned in before you can be licensed as a foster home.

Emergency Numbers

Foster Mom Cell Phone: _____

Foster Dad Cell Phone: _____

AMBULANCE: _____

FIRE: _____

POLICE: _____ 

HOSPITAL: _____

SCHOOLS: _____

_____

 _____

POISON CONTROL: 1-800-222-1222

Benchmark Family Services: _____

BFS Case Manager: _____

BFS Emergency Cell: _____

Disaster Plan

If there is a tornado, go here:

_____

If our home is damaged, meet outside at this place:

_____

A safe place to go in our community:

Name: _____

Address: _____

Telephone: _____

A safe place outside our county:

Name: _____

Address: _____

Telephone: _____

Other Important Numbers:

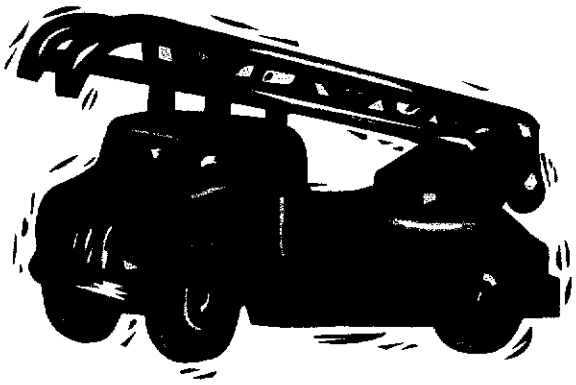
_____

_____

TORNADO EVACUATION

Benchmark Family Services

EVACUATION PLAN



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Doctor Appointment Report

Child's Name: _____ DOB: _____

Date of Appointment: _____

Providers Name: _____

Address: _____

_____

Phone#: _____

Type of Appointment:

Annual Physical Exam: ☐ Sick Visit: ☐ Hearing Screening: ☐
Follow-Up Appointment: ☐ Other: ☐ Vision Screening: ☐

Examination Findings and Treatment Recommendations:

_____

_____

_____

_____

_____

Medication Prescribed	Dosage	Time of Administration:	Possible Side Effects of the Medications:

Signature of Provider: _____ Date: _____

Please return form to Benchmark Family Services

Revised: 6/13/06 CSC; 3/27/09; 5/14/09

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Dental Appointment Report

Child's Name: _____ DOB: _____

Date of Appointment: _____

Providers Name: _____

Address: _____

_____

Phone#: _____

Check-Up Cleaning _____ Cavity Filling(s) _____

Follow-Up Appointment _____ Other _____

Examination Findings and Treatment Recommendations:

_____

_____

_____

_____

_____

Signature of Provider: _____ Date: _____

*please return form to Benchmark Family Services

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317-352-9706
Fax: 317-352-9709
www.benchmarkfamilyservices.org

Optical Appointment Report

Child's Name: _____ DOB: _____

Date of Appointment: _____

Providers Name: _____

Address: _____

_____

Phone#: _____

Exam Information

Exam Only _____ Has Glasses, lens OK _____

Needs Glasses _____ Has Glasses, new lens necessary _____

Examination Findings and Treatment Recommendations:

_____

_____

_____

_____

_____

Signature of Provider: _____ Date: _____

*Please return form to Benchmark Family Services

MEDICATION ADMINISTRATION RECORD for _____ (month/year)

Child's Name:_____ **DOB:**_____ **Height:**_____ **Weight:**_____

Pharmacy Address and Phone #:_____ **Medication Allergy:**_____

	Time	Day 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Refill Due Date
1. Medication:																																	
For:																																	
Dosage:																																	
2. Medication:																																	
For:																																	
Dosage:																																	
3. Medication:																																	
For:																																	
Dosage:																																	
4. Medication:																																	
For:																																	
Dosage:																																	
5. Medication:																																	
For:																																	
Dosage:																																	

Comments:

_____

_____

Name of person(s) who administered the medications:

Print _____ Sign _____ Initials _____

Print _____ Sign _____ Initials _____

Print _____ Sign _____ Initials _____

*****If you make an error initialing in a box you should cross it out with a SINGLE LINE and write (err) for error above it.**

Legend

HV = Home Visit

R = Refused

IR = Incident Report

D/C = Discontinued

FOSTER PARENT MILEAGE-EXPENSE REPORT

Mileage for the Month Of: _____ **Branch Office:** _____

Foster Parent Name(s): _____ **Address:** _____

Date	Child's Name **Sibling Group, List only one child	APPROVED Reason for Travel		Origination Address	Destination Address	Total Miles Per round trip	Deduct Per Round trip (except Visit)	Allowable Miles
		1. Bio Family Visit 2. Pre-Placement 3. Court 4. Therapy 5. Doctor Appt 6. New Placement Pickup 7 Placement discharge	Pre-approved reimburse-ment *					
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
		Number __	☐				-20	
							Total Miles	0
							$ Reimbursed	$0.00

_____ _____

FOSTER PARENT SIGNATURE **DATE** **CASE MANAGER SIGNATURE** **DATE**

*If Pre-Approved Reimbursement Travel, Please Specify _____

Pre-approval signature _____ Date: _____

BENCHMARK FAMILY SERVICES

CLOTHING AND BELONGINGS INVENTORY FORM

Child's Name: _____

Date completed: _____ Initial: _____ Follow-up: _____ Discharge: _____

INSTRUCTIONS: This form is to be completed by the case manager and caretaker of the child upon child's entering and leaving the home. This from must be signed by both the case manager and the caregiver(s).

ESSENTIAL ITEMS	NUMBER CHILD HAS
Underwear	
Bras	
Slip	
Socks	
Pajamas/Nightgowns	
Robe	
Short Sleeve Summer Shirts	
T-shirts	
Winter Tops	
Long Sleeve Dress Shirts	
Turtle Necks	
Sweaters	
Sweatshirts	
Sweat Pants	
Dress Pants	
Casual Pants	
Jeans	
Shorts	
Dress Shoes	
Tennis Shoes	
Casual Shoes	
Boots	
Slippers	
Panty Hose/Tights	
Swimsuit	
Gloves/Scarf	
Belts	
Summer Dresses	
Winter Dresses	
Toys	
Winter Coat	
Spring Jacket	
Rain Coat	

MISC. BELONGINGS

BFS – Foster Parent: _____ Date: _____

BFS – Foster Parent: _____ Date: _____

BFS – Case Manager: _____ Date: _____

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Request for Approval of Alternate Care Giver For the _____ Foster Home

When a foster parent receives his or her license, they need to provide two or more people who will be providing alternate care for the foster child(ren). Alternate care would be defined as short-term care for an evening or during work. Alternate caregivers approved by Benchmark Family Services are the **only** alternate caregivers that a foster family may use. A foster child is **never** to be supervised by an alternate caregiver **overnight**.

Please advise each alternate caregiver that they must provide Benchmark Family Services with information (and payment when applicable) to complete Federal, State, County, and City Criminal History checks as well as Child Protective Services history check and Sex and Violent Offender public registry search.

Alternate Caregiver #1: Name: _____

Street Address: _____

City: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Previous Cities/Counties/States in the last 5 years: _____

Length of time known: _____ Experience with Children: _____

	SENT	RECEIVED	EXPIRATION
Criminal History Background Check (FBI)			
Indiana State Limited Criminal History Information			
County Sheriff's Department Check			
City Police Department Check			
Child Protective Services Check			
Report of Sex and Violent Offender Registry			

Alternate Caregiver #2: Name: _____

Street Address: _____

City: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Previous Cities/Counties/States in the last 5 years: _____

Length of time known: _____ Experience with Children: _____

	SENT	RECEIVED	EXPIRATION
Criminal History Background Check (FBI)			
Indiana State Limited Criminal History Information			
County Sheriff's Department Check			
City Police Department Check			
Child Protective Services Check			
Report of Sex and Violent Offender Registry			

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The applicant below has applied to be a foster parent with Benchmark Family Services. We would appreciate you providing the information requested on this form and returning it in the envelope provided.

EMPLOYER REFERENCE

Name of Applicant:_____

How long has the above named applicant been employed for your company?_____

What is their position with your company?_____

Does the applicant have any problems with absenteeism?_____

Is the applicant dependable?_____

Does the applicant work well with others?_____

How does the applicant handle stressful situations in the workplace?_____

_____

How would you describe their character?_____

_____

_____

Do you feel that there is any other pertinent information that we should know about the applicant relevant to fostering?_____

_____

_____

_____

Reference Taken From:_____ Position:_____

Date:_____

Company Name:_____

Telephone Number:_____

Berea Regional Office
219 Pauline Drive, Ste. B
Berea, KY 40403
859-986-0650
Fax: 859-986-0658
www.Benchmarkfs.org

ADULT CHILDREN REFERENCE

Name:_____

Address:_____

_____

Phone:_____

What is your age? _____

What are your views of your mother/father growing up?_____

_____

_____

_____

What types of discipline were used?_____

_____

_____

_____

How do you feel about your parent(s) becoming a foster parent?_____

_____

_____

_____

What are your parent(s) strengths/weaknesses?_____

_____

_____

_____

Signature_____ Date:_____

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NEIGHBOR REFERENCE

Applicant Name:_____

Applicant Address:_____

The above named applicant has applied to be a foster parent with Benchmark Family Services. We would appreciate you providing the information requested on this form and returning it in the envelope provided.

Neighbor Name:_____

Neighbor Address:_____

In what capacity do you know your neighbors?_____

_____

Approximately how long have you known them?_____

As neighbors to this family, what has been your personal experience with them:_____

_____

_____

_____

_____

_____

_____

Do you feel there is any other important information about your neighbor that we should be provided with?_____
If yes, please explain:

_____

_____

_____

_____

_____

Signature:_____ Date: _____

ALTERNATIVE TRAINING VERIFICATION

State Form 52643 (6-06) / CW 2110

DEPARTMENT OF CHILD SERVICES
402 West Washington Street, Room W392, MS 47
Indianapolis, Indiana 46204-2739

FOSTER PARENT INFORMATION	
Name	Telephone number ( )
Address (*number and street, city, state, and ZIP code*)	

BOOK, VIDEO, OR AUDIO TAPE INFORMATION	
Title	
Author / Presenter	Length of book or tape

What was the book or tape you reviewed about? (*No less than 500 words - add extra sheets, if necessary.*)

ALTERNATIVE TRAINING VERIFICATION (*continued*)

State Form 52643 (6-06) / CW 2110

How does this book / tape relate to your role as a foster parent?

What one new thing did you learn as a result of reviewing this book or tape?

What is one thing you would change about the way you foster children as a result of reviewing this book or tape?

I hereby verify that I reviewed the book or tape named above and that I completed this form based upon my personal knowledge of the material reviewed.	
Signature	Date (*month, day, year*)

To receive training credit, you must mail this form to your licensing worker at the following address:

DISTRIBUTION: White - Local DCS office; Canary - Foster parent