Absentee Shawnee Tribe of Oklahoma
Indian Child Welfare Department
2025 South Gordon Cooper Drive
Shawnee, Oklahoma 74801
Office: 405-395-4490

Dear Applicant,

In order to consider your home for certification, we will need the following information on you and your family:

___ Full names and addresses for ALL references
___ Copy of CDIB/enrollment card for all Native Americans in the home
___ Copy of driver's license for all individuals in the home age 18 or older
___ Copy of current insurance verification for all vehicles
___ Copy of social security card for all individuals in the home age 18 or older
___ Marriage License (if applicable)
___ Divorce Decree (if applicable)
___ Copy of pet vaccinations (if applicable)
___ Consent forms for all individuals in the home age 18 or over:
- DHS request for Background Check (1 form for OSBI and 1 form for fingerprints)
- Department of Public Safety/DPS
- Department of Human Services Child Welfare History check/CANIS

___ Complete fingerprint card
___ Complete ALL required forms (forms enclosed)

If you have any questions or need any assistance with any of the forms please do not hesitate to contact me.

Respectfully,

Shawnee Martinez

Indian Child Welfare
Absentee Shawnee Tribe of Oklahoma

cc: file

INDIAN CHILD WELFARE FOSTER/ADOPTIVE APPLICATION

A. Check the box for type of resource assessment being requested

☐Foster care ONLY ☐ Adoption ONLY ☐Foster-to-adopt ☐Kinship ONLY

☐Short term foster care ☐Long term foster care ☐Emergency/Respite – 24 hours to one month

B. Identifying Information:

Applicant 1: (Last, First, MI)		DOB	Race	Sex	SSN
Other names including maiden				Tribal Affiliation	
Cell Phone	Work Phone			Enrollment/Roll Number	
Email Address					

Applicant 2: (Last, First, MI)		DOB	Race	Sex	SSN
Other names including maiden				Tribal Affiliation	
Cell Phone	Work Phone			Enrollment/Roll Number	
Email Address					

Mailing Address: ____
(P.O. Box, Rural Route, Number or Street) City State Zip Code

Finding Directions: ____
____
____

Married? ☐Yes ☐No Date: ____________________

State: ____ City:____

C. Other Members of Household (list ALL members living in the household):

Household Member 1: (Last, First, MI)	Age	DOB	Sex	SSN

Tribal Affiliation	Enrollment/Roll Number	Cell Phone

Student? ☐Yes ☐No School:
Employed? ☐Yes ☐No Employer:

Household Member 2: (Last, First, MI)	Age	DOB	Sex	SSN

Tribal Affiliation	Enrollment/Roll Number	Cell Phone

Student? ☐Yes ☐No School:
Employed? ☐Yes ☐No Employer:

Household Member 3: (Last, First, MI)	Age	DOB	Sex	SSN

Tribal Affiliation	Enrollment/Roll Number	Cell Phone

Student? ☐Yes ☐No School:
Employed? ☐Yes ☐No Employer:

*****If you need more space for Other Members of the Household please write it on the back of this page*****

D. Precious Marriages:

Number of previous marriages, **Applicant 1**: __________

To Whom	Marriage Date(s)	Divorce Date(s)

Any children from previous marriage, **Applicant 1**? ☐Yes ☐No

Name	DOB	Age	Sex	Live in your home?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Number of previous marriages, **Applicant 2**: __________

To Whom	Marriage Date(s)	Divorce Date(s)

Any children from previous marriage, **Applicant 2**? ☐Yes ☐No

Name	DOB	Age	Sex	Live in your home?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

E. Educational Level: (Circle appropriate number to show highest lever of education)

Applicant 1:			
Highest Grade Completed:		Degrees obtained &Year:	
High School Attended:			
College Attended:			
List any specialized training:			

Applicant 2:			
Highest Grade Completed:		Degrees obtained &Year:	
High School Attended:			
College Attended:			
List any specialized training:			

F. Employment: (List employment for the last 10 years, starting with the most current)

Applicant 1:	Name, Address and Phone # of Employer	
From	To	Reason for leaving
Applicant 1:	Name, Address and Phone # of Employer	
From	To	Reason for leaving
Applicant 1:	Name, Address and Phone # of Employer	
From	To	Reason for leaving
Applicant 1:	Name, Address and Phone # of Employer	
From	To	Reason for leaving

Applicant 2:	Name, Address and Phone # of Employer	
From	To	Reason for leaving

Applicant 2:	Name, Address and Phone # of Employer	
From	To	Reason for leaving

Applicant 2:	Name, Address and Phone # of Employer	
From	To	Reason for leaving

Applicant 2:	Name, Address and Phone # of Employer	
From	To	Reason for leaving

G. Military History:

Applicant 1:			
Branch of service:		Rank:	
Date of entry:		Discharge date:	
Type of discharge:			

Applicant 2:			
Branch of service:		Rank:	
Date of entry:		Discharge date:	
Type of discharge:			

H. Arrest History:

Have you or any member of your family or household ever been arrested for or convicted of a criminal action against a child or domestic violence and/or currently on probation or parole? ☐Yes ☐No

If "YES", who and explain: ____
____
____
____

I. References: List 4 references who are well acquainted with your family, one may be a relative

Name	Address	Phone #

J. Interests and activities:

Are you involved in any social, fraternal, or civic organizations in your community?

Applicant 1: ____

____

____

Applicant 2: ____

____

____

What are your major leisure time activities or hobbies?

Applicant 1: ____

____

____

Applicant 2: ____

____

____

What other activities do you engage in?

Applicant 1: ____

____

____

Applicant 2: ____

____

____

Church Affiliation (***optional***)____

☐ Attend worship regularly ☐ Attend a bible class ☐ Teach a bible class ☐ Attend other church activities
☐ Involved in special ceremonies ☐ Sing in a choir/ play an instrument ☐ Member of supervisory body
☐ Attend other church activities ☐ Involved in volunteer services

Our present pledge to the church budget is $_________ monthly

K. Description of home:

Do you live in a: ☐ City ☐ Small Town ☐ Rural Area

Do you live in a: ☐ House ☐ Apartment ☐Mobile Home

School District: ____

Are there any stairs in your home?: ☐Yes ☐No Square footage: ____________________

Number of bedrooms: ________ Number of beds: _______________ Number of bathrooms: ___________

Is the home owned or rented?: _______________ Monthly mortgage/rent: $__________________________

How long have you lived at this address?: _________________________________

List previous residence if you have not lived in your current residence for more than 5 years

Address	From	To

Sketch a small floor plan of your home on the remainder of this page:

L. Family Background:

Applicant 1:

Father: (Last, First, MI)	DOB	Deceased	Date of Death
		☐Yes ☐No	
Current address		Current or Last Occupation	
Describe your and your father's relationship:			
Mother: (Last, First, MI)	DOB	Deceased	Date of Death
		☐Yes ☐No	
Current address		Current or Last Occupation	
Describe your and your mother's relationship:			

Siblings:	
Number of sisters:	Number of brothers:
Describe your relationship with your siblings (order of birth, frequency of contact and location from you, etc.):	
Grandparents:	
If your grandparents are still living, what is their relationship to you and what is their age?:	
Heritage:	
During your childhood and youth did your family acknowledge your cultural heritage? ☐Yes ☐No	
If yes, how?:	

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Applicant 2:

Father: (Last, First, MI)	DOB	Deceased	Date of Death
		☐Yes ☐No	
Current address		Current or Last Occupation	
Describe your and your father's relationship:			
Mother: (Last, First, MI)	DOB	Deceased	Date of Death
		☐Yes ☐No	
Current address		Current or Last Occupation	
Describe your and your mother's relationship:			
Siblings:			
Number of sisters:	Number of brothers:		
Describe your relationship with your siblings (order of birth, frequency of contact and location from you, etc.):			
Grandparents:			
If your grandparents are still living, what is their relationship to you and what is their age?:			
Heritage:			
During your childhood and youth did your family acknowledge your cultural heritage? ☐Yes ☐No			
If yes, how?:			

M. Additional Information:

From what source did you learn of the Absentee Shawnee Tribe Foster Futures program?

____

____

____

Preferences:

					Justification/Reason:
Ages:	☐ Birth – 5 years	☐ 6 -12 years		☐ 13 - over	
Gender:	☐ Male	☐ Female		☐ No preference	
Foster Siblings:	☐ Yes	☐ No		☐ No preference	
Max # of Siblings:	☐ 2	☐ 3	☐ 4	☐ 5	
Special Needs:	☐ Yes	☐ No		☐ No preference	

If yes, are there any special needs you feel you could NOT provide for? (check all that apply):

☐ School/learning problems	☐ Special medical conditions (asthma, HIV/AIDS, etc)
☐ Developmentally delayed	☐ Sexually abused children/sexualized behaviors
☐ Drug/alcohol exposed or addicted	☐ Premature infants
☐ Behavior disorder or emotionally disturbed (ADHA, Post-Traumatic Stress Disorder, etc.)	

Have you ever cared for a child for any other agency or private individual? ☐Yes ☐No

If yes, please provide the following information:

Name of Agency	Approximate Date	Phone #

____ ____

Applicant 1 Signature Date Applicant 2 Signature Date

____

ICW Caseworker Signature Date

INDIAN CHILD WELFARE PHYSICAL EXAMINATION REPORT

This form is completed by the examining physician. The purpose of the exam is to explore whether the applicant has any conditions that prevent or limit him or her from safely providing, for the next year and possibly into adulthood, daily care for a child(ren) who may have medical or behavioral needs.

Patient Information:

Patient Name:_________________________________ Patient's DOB: _______________

Patient's Address:______________________________ County:_______________

When was this patient first seen? ____

When was this patient last seen, excluding today? _____________________________________

General physical examination information:

Height:____________ Weight:____________ BP: ______________
Pulse: ____________

PHYSICAL EXAMINATION: (Check block if normal. Explain if any evidence of abnormality)

❑ Vision__________ ❑ Hearing_________
❑ Lungs___________ ❑ Heart___________

Medical history

Provide information regarding, but not limited to any surgical procedure or communicable, hereditary, or debilitating diseases, such as diabetes, psychoneurotic disorder, epilepsy, or fainting spells.

Health History: ❑ Convulsive Disorder ❑ Mental Illness ❑ Heart Disease
❑ Tuberculosis ❑ Venereal Disease
❑ Recent Major Injury or Operation (specify) ____

Result of treatment for any item(s) checked/listed above:
❑ Complete Recovery ❑ Partial Recovery ❑ Continued Incapacity

(Attach laboratory reports, as indicated, for tuberculosis, urine, etc.)
General physical condition:____
____
____

List Current medications, dosage, and the reason prescribed. Attach additional sheets when necessary.

Medication	Dosage	Reason medication prescribed

Does this patient have any conditions that impairs his or her ability to safely provide daily care for a child(ren) through the next year and possibly into the child(ren) adulthood?

Yes [ ] No [ ]
If yes, explain:

Does this patient have any emotional or behavioral health issues that would impair his or her ability to safely provide daily care for a child(ren) through the next year and possibly into the child(ren) adulthood?

Yes [ ] No [ ]
If yes, explain:

Examination Date:______________ Physician: ___________________________

______________________________ ____________________________ _____________
Physician signature Printed Name Date

Physician's address:	Physician's phone number: