LICENSING STAFF INQUIRY REGARDING FOSTER FAMILY HOME

State Form 53214 (R2 / 4-11)
DEPARTMENT OF CHILD SERVICES

Date *(month, day, year)*
Due date *(month, day, year)*

INSTRUCTIONS: The Family Case Manager must complete this form during annual review or upon removal of a foster child, whichever occurs first. Return the completed form to the Licensing Worker.

TO:	**ATTENTION:**
Name of family case manager (FCM)	Name of FCM supervisor
FROM:	**REGARDING:**
Name of licensing worker	Name of foster family home / Annual review period

1. List the names of children you have supervised in this home and reasons for removal, if applicable.

NAME	DATE OF PLACEMENT *(in above named foster family home) (month, day, year)*	REASON FOR REMOVAL *(from above-named foster family home, if applicable)*
A.		
B.		
C.		
D.		

2. How would you rate the physical standards, including housekeeping, diet, personal hygiene, and health care? ☐ Above Satisfactory ☐ Satisfactory ☐ Below Satisfactory
3. How would you rate the emotional care provided, and effort at building and maintaining self-concept and essential connections? ☐ Above Satisfactory ☐ Satisfactory ☐ Below Satisfactory
4. Have you any concerns regarding discipline or child rearing practices? ☐ Yes ☐ No
5. Have these foster parents been able to work cooperatively with the department and service providers? ☐ Yes ☐ No

6. Explain all negative ratings and any additional comments:

Signature of placing family case manager	Date (*month, day, year*)