IOWA Health and Human Services

Kinship Foster Care Approval Application

You are receiving this application to be a formal kin caregiver for a child who has been separated from their parents or caregivers and is in the custody of the child welfare system. We consider any adult with a meaningful relationship to the child a family member (or “kin”), even if you are not related by blood or marriage.

Our agency is committed to ensuring a safe environment for the child and this means considering everything we can about whoever cares for them while they are separated from their home. In addition to ensuring child safety, getting approved as a kin caregiver has benefits for your household such as:

- Funds to assist with expenses
  - Monthly support payment
  - Childcare
  - Clothing Allowance
- Service referrals to support the child
- Support for caregivers

The application to become a formal kin caregiver includes all of the following checks:

- Criminal background records, including fingerprinting Child abuse and neglect records
- Out of state background checks
- Sex offender registry records
- Home assessment to make sure your home is safe for the child, completed by the caseworker while you are present
- Suitability assessment to make sure you’re able to care for the child

To complete the above checks, you will need to show an ID, like a driver's license or passport. Refer to the fingerprinting ID form for more information. If you have a social security number or a tax ID number (ITIN), we recommend sharing it to get the fastest background checks results.

Talk with your caseworker if you need these forms in a different language, accommodations for a disability, or do not understand something for any reason. Your caseworker will refer you to resources, including the opportunity to connect with other kin caregivers.

We recognize that this process looks into highly sensitive information about you, your past, and your home. For example, even if you have a record, the agency might be able to approve you, so long as there is proof that it will not affect the child’s safety and well-being.

Thank you for going through this application process and offering a home for your family member.

Kinship Foster Care Application

This form is used to apply to Agency to get approved as a formal kin caregiver. If you have any questions about this form, please contact your caseworker for assistance. Please print clearly when completing this form. Questions about sex, race, and ethnicity are collected for statistical purposes.

Section 1: Kinship Placement Child Information

Child 1			
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Child 2			
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Child 3			
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

For applications with more than 3 children, please attach an additional version of this sheet.

Section 2: Kinship Applicant Information

Applicant 1			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Other names used (birth, previous, etc.)			
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Email		
Cell Phone	Work Phone	Home Phone	
If you lived out-of-state in the past 5 years, list each city or county and state.			
Current Address			
Street	Apt. or Building		
City	State	ZIP Code	
Signature	Date		

Applicant 2			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Other names used (birth, previous, etc.)			
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Email		
Cell Phone	Work Phone	Home Phone	
If you lived out-of-state in the past 5 years, list each city or county and state.			
Current Address		☐ Same as Applicant 1	
Street	Apt. or Building		
City	State	ZIP Code	
Signature		Date	

Note: If you require more space to list out-of-state addresses, please use additional pages at the end of this document.

Section 3: Other Adults Living in the Home

Include anyone aged 18 or over who regularly lives, shares common areas, and sleeps in the home for 30 days in a row. Talk with your caseworker about whether someone needs to be listed.

Other Adult 1		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Other Adult 2		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Other Adult 3		
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Other Adult 4		
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Other Adult 5		
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Other Adult 6		
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)
Other names used (birth, previous, etc.)		
Relationship to Caregiver (Applicant 1)		Date of Birth (MM/DD/YYYY)
If you lived out-of-state in the past 5 years, list each city or county and state.		
Signature		Date

Note: If you require more space to list out-of-state addresses, please use additional pages at the end of this document.

Child			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Child			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Child			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race or Ethnicity (how they identify)	
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Child			
First Name	Middle Name (“none” if no middle)	Last Name (include Jr. Sr. etc.)	
Date of Birth (MM/DD/YYYY)	Sex ☐ M ☐ F	Race	Ethnicity
Tribal Affiliation (if any)	Relationship to Caregiver (Applicant 1)		

Appendix 2: Additional Page for Applicant Addresses

Applicant		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

Applicant		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

Appendix 3: Additional Page for Other Adults Living in the Home Addresses

Other Adult		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

Other Adult		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

Other Adult		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

Other Adult		
First Name	Middle Name ("none" if no middle)	Last Name (include Jr. Sr. etc.)
If you lived out-of-state in the past 5 years, list each city or county and state.		

You Have the Right to Appeal

What is an appeal? An appeal is asking for a hearing because you do not like a decision the Department of Health and Human Services (HHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal? You can appeal in person or in writing for. You must appeal in writing for all other programs by doing **one** of the following:

A. Complete an appeal electronically at: https://hhs.iowa.gov/programs/appeals **or**
B. Write a letter telling us why you think a decision is wrong, **or**
C. Fill out an Appeal and Request for Hearing form. You can get this form at your county HHS office.

Send or take your appeal to the Iowa Department of Health and Human Services, 321 E 12th Street, Des Moines, Iowa 50319. If you need help filing an appeal, ask your county HHS office.

How long do I have to appeal? You must file an appeal within 30 calendar days of the date of a decision or before the date a decision goes into effect.

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing. If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending? You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice. Any benefits you get while your appeal is being decided may have to be paid back if the HHS's action is correct.

How will I know if I get a hearing? You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing? You or someone else, such as a friend or relative, can tell why you disagree with the HHS's decision. You may also have a lawyer help you, but HHS will not pay for one. Your county HHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 515-243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa HHS to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, religion, age, disability, political belief or veteran status.

If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa Department of Health and Human Services, 321 E 12th Street, Des Moines, Iowa 50319 or via email FDHS@hhs.iowa.gov

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Additionally, program information may be made available in languages other than English.

This institution is an equal opportunity provider.