MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

P O BOX 88
JEFFERSON CITY MO 65103

APPLICATION FOR LICENSE TO OPERATE A CHILD PLACING AGENCY

☐ INITIAL ☐ RENEWAL

We hereby make application to the Division of Family Services, Department of Social Services, for a License to operate a Child Placing Agency. We agree to abide by the Rules and Regulations prescribed by the Division of Family Services.

1. NAME OF AGENCY (AS IT WILL APPEAR ON LICENSE)	2. TELEPHONE NUMBER

3. ADDRESS (STREET NUMBER, CITY, COUNTY, ZIP CODE)

4. TYPE(S) OF SERVICE TO BE PROVIDED (CHECK ALL THAT APPLY)
- ☐ ADOPTION
- ☐ FOSTER HOME PLACEMENT
- ☐ FOSTER HOME LICENSE RECOMMENDATION

5. OPERATING SITES: (USE THE ATTACHED RL-8E)

a.

b.

c.

d.

6. CONDUCTED UNDER THE AUSPICES OF (NAME OF SPONSORING ORGANIZATION)

7. DATE ORGANIZED	8. DATE INCORPORATED

9. CURRENTLY ACCREDITED BY

10. ORIGINAL ACCREDITATION DATE	11. TERM OF ACCREDITATION

12. LIST ALL STATES IN WHICH AGENCY HOLDS AN ACTIVE CHILD PLACING LICENSE

13. IS THERE ANY PENDING LEGAL ACTION AGAINST THE AGENCY, ANY BOARD MEMBER OR ANY STAFF MEMBER INVOLVING THE OPERATION OF THE AGENCY? IF YES, EXPLAIN ON A SEPARATE PAGE. ☐ YES ☐ NO

NOTE: Any person who violates any applicable provision of sections 210.481 to 210.536, or who for himself or for any other person makes materially false statements in order to obtain a license or the renewal thereof shall be guilty of a Class A misdemeanor. In case such guilty person be a corporation, association, institution, or society, the officers thereof who participate in the activity shall upon conviction be subject to the penalties provided by law.

I certify the information provided with this application and attachments to be true.

SIGNATURE OF DIRECTOR OR BOARD CHAIRMAN	DATE
▶	

TITLE

MO 886-3333 (3-96) RPU-88

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES/RESIDENTIAL PROGRAM UNIT

PROFESSIONAL AND ADMINISTRATIVE STAFF

PERSONNEL REPORT RESIDENTIAL CARE AND CHILD PLACING AGENCIES

NAME OF AGENCY	ADDRESS

NAME	TITLE	DATE OF BIRTH	EXP. **	EDU ***	DEGREE	ANNUAL SALARY	DATE OF PHYSICAL EXAM	DATE OF TB TEST AND RESULT	DATE OF LAST CRU CHECK	NO. OF HOURS STAFF TRNG. ****

* INCLUDE CONSULTANTS AND PART-TIME STAFF. FOR EACH, INDICATE THE ANTICIPATED NUMBER OF HOURS SCHEDULED DURING THE BUDGET YEAR AND INCLUDE THEIR RATE OF SALARY.
** EXPERIENCE IN THE FIELD IN YEARS
*** EDUCATION COMPLETED IN YEARS
**** NUMBER OF HOURS STAFF TRAINING IN LAST CALENDAR YEAR

MO 886-3331 (4-96) RPU-10A

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES
RESIDENTIAL PROGRAM UNIT

MEDICAL EXAMINATION REPORT FOR CHILD CARE PROVIDER/STAFF

I. IDENTIFYING INFORMATION (TO BE COMPLETED BY PATIENT)

NAME	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )
NAME OF CHILD CARE FACILITY WHERE EMPLOYED	

II. TO BE COMPLETED BY A LICENSED PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A LICENSED PHYSICIAN

	YES	NO
This individual will be in contact with children, ________ through ________ ,receiving child care outside their own homes. S/he may be responsible for the physical care and social development of young children during daytime and/or nighttime hours. Some lifting of young children may be required. On ____________________ (date) I examined this patient and certify –		
A. That s/he is in good physical and emotional health and free of contagious disease;		
B. To the best of my knowledge s/he is free of impairment due to the use of medication;		
C. To the best of my knowledge s/he is free of a current drug or alcohol dependency; and		
D. That s/he is free of active tuberculosis as established by a tuberculin skin test, a chest x-ray, or appropriate follow-up of a previous examination. (If chest x-ray is contra-indicated, please comment on follow-up indicating if this person will pose a hazard to other persons). TB testing, chest x-ray, or follow-up examination was completed on ____________________ (date).		
Does patient have any physical or mental conditions which might endanger the health of children or that might prevent him/her them from providing adequate care for children? If yes, explain below.		
Are there any restrictions on chiidren's ages, number of children or hours of care? If yes, explain below.		

Remarks/Restrictions, if any:

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN ►	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )

MO 886-3334 (4-96) THIS REPORT IS TO BE KEPT ON FILE AT THE RESIDENTIAL CARE OR CHILD PLACING AGENCY RPU-10C

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES
RESIDENTIAL PROGRAM UNIT

CHILD'S MEDICAL REPORT

NAME				DATE OF BIRTH		MEDICAID NUMBER	
RACE	SEX	HEIGHT	WEIGHT	TEMP	PULSE	RESP	BP

HISTORY OF ILLNESS: (ENTER THE YEAR IN WHICH CHILD HAD THE FOLLOWING:

CHICKEN POX		TUBERCULOSIS		PNEUMONIA		DIABETES	
MUMPS		RUBELLA		SEIZURE DISORDER		ASTHMA	
RHEUMATIC FEVER		SCARLET FEVER		MEASLES		POLIOMYELITIS	
HEPATITIS (JAUNDICE)		MENINGITIS		STREP THROAT			

DATE AND TYPE OF TB TEST GIVEN	RESULT OF TB TESTING

KNOWN ALLERGIES

MEDICATIONS PRESCRIBED AND PURPOSE

FINDINGS OF THE PHYSICAL EXAMINATION

FINDINGS OF A NEUROLOGICAL EXAMINATION

LABORATORY OR TEST RESULTS

ARE ANY ADDITIONAL TESTS NEEDED? ☐ YES ☐ NO
IF YES, SPECIFY:

This child will be engaging in a full range of physical activity and recreation. Are there any significant physical disabilities which could limit this child's engagement in strenuous physical activities? If yes, please specify: ☐ YES ☐ NO

TREATMENT RECOMMENDED

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN ▶	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )

MO 886-3332 (4-96) **THIS REPORT IS TO BE KEPT ON FILE AT THE RESIDENTIAL CARE OR CHILD PLACING AGENCY** RPU-10D

HISTORY OF IMMUNIZATION REQUIRED BY MISSOURI STATE LAW															
	1ST			2ND			3RD			4TH			5TH		
INITIAL SERIES	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR	MONTH	DAY	YEAR
DPT															
T.d.															
POLIO ORAL															
MEASLES															
MUMPS															
RUBELLA															
MMR															
HIB															
HBV															
TB TEST															

MO 886-3332 (4-96)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES/RESIDENTIAL PROGRAM UNIT

STATISTICAL REPORT

NAME OF AGENCY			CALENDAR YEAR (January 1 through December 31)	
	PREVIOUS YEAR		CURRENT YEAR	
CITIZENSHIP AT TIME OF PLACEMENT	US CITIZEN	NON US CITIZEN	US CITIZEN	NON US CITIZEN
Number of children placed in foster care				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Average length of stay of children in foster care (days)				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of children placed for adoption				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
For International Placements:				
ASIAN				
ASIAN INDIAN				
EASTERN EUROPEAN				
SOUTH AMERICA				
OTHER (LIST BY COUNTRY)				
Number of foster home studies completed				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of foster homes licensed				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of adoptive studies completed				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				

MO 886-3328 (4-96) RPU-16

NAME OF AGENCY			CALENDAR YEAR (January 1 through December 31)	
	PREVIOUS YEAR		CURRENT YEAR	
CITIZENSHIP AT TIME OF PLACEMENT	US CITIZEN	NON US CITIZEN	US CITIZEN	NON US CITIZEN
Number of families who received a child for adoptive placement				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of families currently under adoption				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of families who finalized adoption				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of birth parents served who relinquished				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				
Number of birth parents who chose to parent				
WHITE				
AFRICAN AMERICAN				
HISPANIC				
ASIAN				
NATIVE AMERICAN/ESKIMO				
OTHER				

1. For agencies providing International Adoption Services, list the countries of origins and number of children placed from each country. ☐ YES ☐ NO
2. Has your agency placed any children from a foreign country or from the United States, outside the fifty states? If yes, list the number of children and country/territory of ☐ YES ☐ NO
3. Has your agency placed any Missouri children outside the state of Missouri? If yes, list the number of children and the country, territory or state of placement.
4. List by name and departmental vendor number (DVN) any ofster home or adoptive home revocations or disruptions during the year.
5. List by name and address any active foster/adoptive family who had allegations of child abuse and neglect made to the Central Registry of the Division of Family Services; and disposition, if known.

MO 886-3328 (4-96)

RPU-16

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES
RESIDENTIAL PROGRAM UNIT

CIVIL RIGHTS AGREEMENT

TO: ALL LICENSED RESIDENTIAL AGENCIES FROM WHICH CARE OR SERVICES ARE PURCHASED BY THE DIVISION OF FAMILY SERVICES

FROM: THE DIRECTOR OF THE MISSOURI DIVISION OF FAMILY SERVICES

SUBJECT: CIVIL RIGHTS INFORMATION AND AGREEMENT FORM

Public Law 88-352, the Federal Civil Rights Act of 1964, states as follows in Section 601, Title VI of the Act: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Under the authority of section 602 of Title VI of the Act, the Secretary of the U.S. Department of Health, Education and Welfare has promulgated a regulation carrying out the intent of the Act as it applies to programs and grants which receive Federal financial assistance through the Department. This Regulation is set forth in Title 45, Code of Federal Regulations, Part 80. Subsection 80.5 is stated in part as follows: "(a) In grant programs which support the provision of health or welfare services, discrimination in the selection or eligibility of individuals to receive the services, and segregation or other discriminatory practices in the manner of providing them, are prohibited. This prohibition extends to all facilities and services provided by the grantee under the program or, if the grantee is a State, by a political subdivision of the State. It extends also to services purchased or otherwise obtained by the grantee (or political subdivision) from hospitals, nursing homes, schools, and similar institutions for beneficiaries of the program, and to the facilities in which such services are provided, subject, however, to the provisions of 80.3(e)" (which refers to sheltered workshops under Vocational Rehabilitation.

In view of the above it is mandatory for the Division of Family Services, if it is to continue receiving Federal funds for financing the public assistance, medical care, vocational rehabilitation for the blind, and social service programs in Missouri, to receive from each person, agency, or institution from which care or services are purchased for applicants or recipients of assistance or services, written assurance of compliance with the Civil Rights Act.

We are enclosing two copies of Attached form, RPU-32, "Civil Rights Agreement Form". Will you please fill out both forms, sending the original to the State Supervisor, Residential Program Unit, Division of Family Services, P.O. Box 88, Jefferson City, Missouri 65103, within thirty (30) days and keep one copy for your file.

This agency or organization hereby gives assurances to the Missouri Division of Family Services that:

1. The care and services offered is available to any person without discrimination regardless of race, color, or national origin; and
2. Such report as may be required by the Division in connection with the Civil Rights Act of 1964 will be provided when necessary.

NAME OF AGENCY	DATE
MAILING ADDRESS	
SIGNATURE OF ADMINISTRATOR OR EXECUTIVE DIRECTOR ►	SIGNATURE OF PRESIDENT OF BOARD OF DIRECTORS ►

MAIL ONE COPY WITHIN 30 DAYS TO: MISSOURI DIVISION OF FAMILY SERVICES
RESIDENTIAL PROGRAM UNIT
P.O. BOX 88
JEFFERSON CITY, MO 65103

MO 886-3329 (4-96) "AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER" RPU-32