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|  | NAME OF APPLICANT(S): |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**FOSTER/ADOPTIVE APPLICANT**

**MEDICAL REPORT (PART ONE)**

**Instructions:**

**Applicant:** There are three sections to this form. **Section 1** is to be completed by the applicant. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for the applicant.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant.Provide one form per applicant member.

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| **PART 1 - Section 1: APPLICANT'S INFORMATION** | | |
| Name of Applicant | | |
| Last, First, Middle initial: | DATE OF BIRTH:       /       / | Telephone Number:  (     )       - |
| Address of applicant: | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | |
| APPLICANT’S SIGNATURE:  **X** | | |
| Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must cover a physical examination of the applicant conducted not more than one year preceding the date the application for certification or approval is submitted to the certifying or approving agency. | | |

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| **PART 1 - SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME:  OCDSS |
| AGENCY’S ADDRESS:  11 Quarry Rd Box Z Goshen NY 10924 |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER):  PatriciaPineda (845)2912966 |

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| **PART 1 - SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each applicant. | | |
| **Please respond to each of the following to the best of your knowledge:** | | |
| Physical Exam Date:        /       / |  | |
| Are there any chronic or serious disorders or conditions for which this individual has received or is receiving treatment that might affect the proper care of foster/adoptive child(ren)? | | No  Yes\* |
| \*If yes, please provide an explanation. | | |
| Is this individual currently taking medications that might affect the proper care of foster/adoptive child(ren)? | | No  Yes\* |
| \*If yes, please provide an explanation. | | |
| Have you or your medical organization ever referred this individual to treatment for alcohol/substance use? | | No  Yes\* |
| \*If yes, please provide and explanation and indicate the dates the referral(s) were made. | | |
| Does the individual have any communicable disease, infection, or illness that might affect the proper care of foster/adoptive child(ren)? | | No  Yes\* |
| \*If yes, please provide an explanation. | |  |
| Does the individual have any physical or mental condition that might affect the proper care of  foster/adoptive child(ren)? | | No  Yes\* |
| \*If yes, please provide an explanation. | |  |

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| NAME OF APPLICANT(S): | | |
| Does the presence of any identified affliction pose a risk to the health and safety of foster/adoptive child(ren)? | | | | | | No  Yes\* |
| \*If yes, please provide an explanation: | | | | | |  |
| **FINDINGS** | | | | | | |
| On the basis of my findings, as indicated above, and my knowledge of the individual, I find that the above listed individual is: | | | | | | |
| Physically and mentally able to give adequate care to foster/adoptive child(ren) with no restrictions. | | | | | | |
| Physically and mentally able to give adequate care to foster/adoptive child(ren) with the following restrictions or supports: | | | | | | |
| Not physically able to give adequate care to foster/adoptive child(ren). Explain:  Not mentally able to give adequate care to foster/adoptive child(ren). Explain: | | | | | | |
| If the individual is an adoptive applicant, on the basis of my findings, as indicated above and my knowledge of the individual, I find that the above-listed individual:  **IS**  **IS NOT** in such physical condition that it is reasonable to expect them to live to the child(ren)’s age of majority and have the energy and other abilities needed to fulfill parental responsibilities. | | | | | | |
| medical care provider’s signature:  **X** | | Telephone Number:  (     )       - | | | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’S printed name: | | | | | | |
| MEDICAL CARE PROVIDER’s Address: | | | | | | |
| **NYC ONLY:** | NPI #: | | License #: | | | |
| PHYSICIAN OR CLINIC STAMP: | | | | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | | | | |

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|  | NAME OF APPLICANT(S): |

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

**HOUSEHOLD MEMBER MEDICAL REPORT (PART TWO)**

**Instructions:**

**Applicant(s):** There are three sections to this form. **Section 1** is to be completed by the applicant if the household member is under 18 years of age or by the household member if 18 years of age or older. **Section 2** is to be completed by the agency. **Section 3** is to be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member.

**Home finder:**This form is to be used for initial application and reauthorization. Complete **Section 2** before providing form to applicant(s). Provide one form per household member.

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| **PART 2 - SECTION 1: household member’S information** | | | |
| Last, First, Middle Initial: | | DATE OF BIRTH:        /       / | Telephone Number:  (     )       - |
| NAME OF applicant(S): | RelationSHIP to APPLICANT(S): | | |
| Address of applicant(S): | | | |
| I hereby request and authorize my physician to release the following information to the agency named below. | | | |
| household member Or Parent/guardian if Household Member is under 18 years of age Signature:  **X** | | | DATE:        /       / |
| The above-named individual(s) is residing in the home of an individual(s) who is seeking to foster or adopt a child(ren). Per New York State regulations, the agency is required to obtain a medical report regarding the family’s health. Such report must show that each member of the household is in good physical and mental health and free from communicable disease, infection or illness. | | | |

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| **PART 2 - SECTION 2: AGENCY’S INFORMATION** |
| AGENCY’S NAME: |
| AGENCY’S ADDRESS: |
| AGENCY’S CONTACT (NAME AND PHONE NUMBER): |

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| **PART 2 - SECTION 3:** To be completed by a physician, physician assistant, nurse practitioner, or other licensed and qualified health care practitioner for each household member of an applicant(s). | | | |
| Does the individual have any communicable disease, infection, or illness that might affect the proper care of foster/adoptive child(ren)? | | | No  Yes \* |
| \*If yes, please provide an explanation. | | | |
| Does the individual have any physical or mental condition that might affect the proper care of foster/adoptive child(ren)? | | | No  Yes \* |
| \*If yes, please provide an explanation. | | | |
| Does the presence of any identified affliction pose a risk to the health and safety of foster/adoptive child(ren)? | | | No  Yes\* |
| \*If yes, please provide an explanation. | | | |
| medical care provider’s signature:  **X** | Telephone Number:  (     )       - | Date Signed:        /       / | |
| MEDICAL CARE PROVIDER’S printed name: | | | |
| MEDICAL CARE PROVIDER’s Address: | | | |

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|  | | | | NAME OF APPLICANT(S): |
| **NYC ONLY:** | NPI #: | | License #: | |
|  | | Physician or Clinic Stamp: | | |
| **Return completed report to AGENCY CONTACT LISTED IN SECTION 2.** | | | | |

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