STATE OF MONTANA
Department of Public Health and Human Services
Child and Family Services Division

PERSONAL STATEMENT OF HEALTH FOR LICENSURE AND/OR APPROVAL TO ADOPT OR BECOME A GUARDIAN

NAME: (Birth Date)

(Address) (City) (Zip Code)

(Work Telephone) (Home Telephone)

TYPE OF APPLICATION:

☐ Foster Home ☐ Adoptive Home Application is to ☐ DPHHS ☐ Child Placing Agency

☐ Guardianship Home ☐ Kinship Home

_____
Name of Agency

Applicants and providers must meet certain personal health requirements. As the agency responsible for licensure and approval, the Department of Public Health and Human Services/Child and Family Services (DPHHS/CFSD) must ensure that the health of all providers is adequate to meet the demands of the care to be or being provided and that the health of other household members would not be detrimental to children who may be placed in the home.

Please answer the following questions by entering an "X" in the appropriate box for each question.

The Family Resource Specialist or Child Placing Agency staff member completing the licensure study and the Family Resource Specialist Supervisor who issues the license will review this form. **In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your responses.** The answer "yes" does not mean you will automatically be denied a license or approval. Your explanation or, if necessary, your physician's or other appropriate professional's statement, will be taken into consideration. The purpose of the questions is to help decide if you have health problems that may affect your ability to safely provide care. The licensing worker or supervisor will discuss with you the type of additional information needed. If an evaluation or statement is needed, the licensing worker will assist you in completing the authorization form for your physician or other appropriate professional.

You are responsible for payment of the costs for any evaluations, tests or visits to your physician and other professional(s).

	YES	NO	
1.	☐	☐	Do you have any physical or mental health conditions? (If yes, please explain on reverse side.)
2.	☐	☐	Are you currently using medical marijuana for any physical or mental health conditions? (If yes, please explain in on reverse side)
3.	☐	☐	Are you currently receiving therapy or medication for a physical or mental health condition? (If yes, please explain on reverse side.)
4.	☐	☐	Have you received counseling or treatment related to chemical dependency or drugs or alcohol within the past three years? (If yes, please explain in on reverse side.)

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5. Please use the space below to explain any "yes" answers marked in question 1 through 4.

_____
_____
_____
_____
_____
_____
_____

PLEASE READ, THEN SIGN AND DATE:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or revoking my foster care license **and/or** denying my application or withdrawing my approval as a foster care, kinship, guardianship or adoptive home should such licensure or approval have been based on the statement I have made herein. I understand this information is confidential and to be used by the Department of Public Health and Human Services/Child and Family Services Division for the administration of the foster care, kinship, guardianship and adoption programs. I hereby consent to the use of this information for such purposes.

IF THIS FORM IS BEING COMPLETED FOR A MINOR CHILD, A PARENT SHOULD SIGN THE FORM.

SIGNATURE DATE

Please Return To:
Name: _____
Address: _____
City, ST, Zip: _____