The Delaware Foster Care Transitional Resource Center, Inc.
(DFCTRC)

Please print out this application, fill it in with pen and mail it to:

DFCTRC
2003 Jefferson Street
Wilmington, DE 19802

Membership Application

To be eligible for membership an applicant must:

1. Be interested in attending (DFCTRC) Inc..
2. Be aged out of the foster care system.
3. Be able to get to (DFCTRC) Inc.
4. Not pose a threat to our community.
5. be at least 18 years of age.

Currently, we are currently accepting applications for people who belong to one of the following categories**:**

1. Member returning to (DFCTRC) after a significant absence.
2. Applications former foster care residents enrolled in the DVR program
3. Applicants age 18 and older
4. Applicants aged out of foster care
5. Applicants in the life lines program

Who is recommending you?
Name:_____Agency:_____
Phone: _____Type of Agency:_____
How long have you known this person?_____
Email Address: _____

Prospective Member

First:_____MI:___
_____Last:_____
DOB:_____SSN:_____-_____-_____ Place of birth:_____

Address
Street:_____Apt:_____
___
City:_____State:_____Zip:_____
___
Phone:_____County:_____
___
How long have you resided here?
_____
Email Address:
_____

Why would (DFCTRC) be a good place for you?:_____
_____
___

Current Housing Type (circle one)

1). Own Home/ Apartment (Non-subsidized)
2). Home of Family Member
3). Rooming/ Boarding House, Hotel
4). SRO (Temporary)
5). Supported Apt. (Subsidized)
6). 24 Hr. Supervised Housing
7). Supportive Apartment
8). Supervised Housing (Part-time Supervision)
9). Foster Care
10). Psychiatric Hospital
11). Nursing Home
12). Prison/ Jail
13). Shelter
14) Homeless/ Undomiciled

Current Housing Status (circle all that apply)
1). Alone
2). With Room/ Housemate(s)
3). With Spouse/ Partner
4). With Parents

Satisfaction with Housing (circle one)
1). Very Satisfied
2). Somewhat Satisfied
3). Neutral
4). Somewhat Unsatisfied

5). With Other Adult Relative
6). Institutional Setting

5). Very Unsatisfied

Do you have a history of homelessness? _____ If so, please explain:
_____
_____
_____

Do minor children reside in your home? _____
If so, is there or has there ever been any ACS (Administration for Children's Services) involvement?
_____

Income (circle all that apply & enter monthly amounts)
SSI: $_____ Family Support: $_____ Veteran's Benefits: $___
_____
SSDI: $_____ Friend Support: $_____ Public Assistance: $_____
Wages: $_____ Retirement Benefits: $_ Other:_____

Total Income:
$_____

Ethnicity (circle all that apply)

African-American American Indian/Native American Caucasian
Asian/Chinese/Japanese/Korean Middle Eastern Pacific Islander
Latino/Hispanic/Cuban/Mexican/Puerto Rican Caribbean/Haitian/Jamaican
Other:_____
__

Primary Language If other than
English,_____

Marital Status (circle one) Married Permanent Partner Separated Divorced
Widowed Single, Never Married

Veteran Status Are you a veteran? **YES** **NO**

Education Level (circle all that apply)

Less than High School Some High School GED High School Diploma
Trade School Some College Junior College Associate's
Degree Bachelor's Degree Some Graduate Work Master's Degree
Advanced Graduate Degree

School Attended	Years	Major	Did you Graduate?

Employment History

Have you ever worked for pay? **YES** **NO**
Have you worked in the last 12 months? **YES** **NO**
Estimated TOTAL YEARS you have worked for pay:_____
Estimated TOTAL NUMBER OF JOBS worked for pay:_____

Please List All Employment. Be sure to include the most recent and longest job:

Dates	Employer	Title/ Type of work	Hourly Wage & Hours per week.

Notes:

Medical Alerts (circle all that apply) Chronic Physical Illness Severe Allergic Reactions
Deaf/Hearing Impairment Asthma New Psychiatric Medication Blind/Visual Impairment
Recent Surgery Diabetes Epilepsy/Seizure Disorder Hypertension
Other:_____
___

Alert Memo:
_____

Medical & Psychiatric Contacts

Psychiatrist: Agency: Phone:

Address:

How long have you been seeing this psychiatrist?
_____

Email
Address:_____

_____

_____

Therapist: Agency: Phone:

Address:

How long have you been seeing this therapist?
_____
Email
Address:_____

_____

_____

Primary Care MD: Agency: Phone:

Address:
Email
Address:_____

_____

_____

Clinic: Phone:

Emergency Contacts
Primary:_____Phone:_____
___
Relationship:
_____

Secondary:_____Phone:_____
___
Relationship:
_____

Medical Insurance (indicate applicable insurance and provide the policy number)

Medicaid:_____ Private
Insurance:_____
Medicare:_____ Veteran's
Benefits:_____
Family pays:_____ Worker's Compensation:
_____

Self-pay:_____
Other:_____

Date of Last Physical Exam:_____ Date of Last Dental Exam:_____

Medications (please list all medications with respective dosage)

_____
_____
_____
_____

Psychiatric Hospitalizations Total # of Hospitalizations:_____

Please list all hospitalizations beginning with the first. Be sure to indicate the most recent.
Indicate name of hospital & dates:

1). 6).

2). 7).

3). 8).

4). 9).

5). 10).

Please indicate precipitants to these hospitalizations:
_____
_____
_____
_____

Substance Abuse History Please answer all questions. Indicate N/A if not applicable.

	Drugs	Alcohol
Do you have a history of alcohol or drug abuse?	**YES NO**	**YES**
NO How long have you been clean and sober?	_____months	

If an alcohol or drug abuse history exists, please elaborate:
_____
_____
_____

Name of Substance	Date Started	**Last Use**

Have you ever been in treatment for an alcohol or drug problem? **YES** **NO**

Name of program:_____ Date of completion:_____

Are you currently in treatment or in a support group? **YES** **NO**

Are you interested in being in treatment or a support group for alcohol or drug abuse? **YES** **NO**

Legal History Please answer all questions. Indicate N/A if not applicable.

Have you ever been in jail? **YES** **NO**

Have you ever been in prison? **YES** **NO**

Have you ever been convicted of a misdemeanor? **YES** **NO**

Have you had any arrests for felonies? **YES** **NO**

Have you ever physically injured another person? **YES** **NO**

Do you have any history of violent behavior? **YES** **NO**

If any of the above questions were answered "YES", indicate dates, behaviors, precipitants, legal actions, etc.

_____
_____
_____
_____
_____
_____

It is very important that all components of this application are complete. Any missing or incomplete components will, unfortunately, delay the application process. In addition, it is helpful to include all three pieces of information at the same time.

Please allow the Membership Team approximately two weeks to review applications.

Please contact the Membership Office at (302) 656-2655 with questions.

Did you remember to include: _____

1). a current and detailed psychosocial history
2). a current psychiatric assessment

Member Signature _____

Date: _____

Referral Source Signature _____

Date: _____

Thank you for applying to The Delaware Foster Care Resource Center.

The Delaware Foster Care Transitional Resource Center, Inc."
has final determination regarding its acceptance of new members.