



Parent to Parent Network Provider Application

I. IDENTIFYING INFORMATION

Provider 1 Full Name: _____

Provider 2 Full Name: _____

II. CONTACT INFORMATION

Street Address: _____

City: _____

State: _____

Zip Code: _____

Mailing Address (if different from above): _____

City: _____

State: _____

Zip Code: _____

Telephone: _____

Fax: _____

Other Telephone (message phone or cell phone): _____

E-mail Address: _____

Days and Hours Available: _____

III. EMPLOYMENT & CURRENT HOUSEHOLD COMPOSITION

Employer: _____

Phone Number: _____

Work hours: _____

Employer: _____

Phone Number: _____

Work hours: _____

List individuals living in home:

Name	Age	Relationship*

*For children relationship please indicate foster, adoptive or biological



IV. TRAINING AND CERTIFICATIONS

List Certificates, Licenses, and Relevant Training or Skills (e.g. CPR, First Aid):

Check all the fields below that you have experience or, when applicable, certification in:
 Please attach a narrative describing your experience.

Behavior Related Disabilities

- Behavior Management
- Autism/PDD
- ADD/ADHD

Developmental Disabilities

- Speech/Language delay
- Developmental delay
- Mental Retardation

Medical/Genetic Disabilities

- Hearing Impaired
- Vision Impaired
- Down Syndrome

- Speech/Language delay
- Cerebral Palsy
- Shunt knowledge

Medical Issues

- Injections
- Allergies
- Asthma
- Diabetes

- Sickle Cell Anemia
- Breathing Treatments/Meds
- Seizure disorder
- HIV/Hepatitis B

Special Education Services

- Speech/Language Therapy
- Physical Therapy
- Developmental Therapy

Supports child uses

- Special diet/Food allergies
- Wheelchair/crutches accessible
- Sign Language

V. AVAILABILITY AND PREFERENCES

Specific Geographic Area you will serve (such as part of town or county): _____

Age group you will serve: 0 – 2 3 – 4 5 – 10 11 – 13 14 – 18

Tell us about your scheduling options for parents:

Hours – From: _____ To: _____ Mon Tues Wed Thur Fri Sat Sun

List any restrictions to your service (e.g. medical conditions, transportation): _____

What languages do you speak? English Spanish Other _____

Have you ever been convicted of a felony or are you currently involved in a pending criminal case? Yes No

If yes, please explain the charge or finding, the date and the court involved:



Foster & Adoptive Care Coalition

FOR EVERY CHILD... A PLACE TO CALL HOME

By signing this form you 1) agree to be listed as a Parent-To-Parent Network Provider on the Parent-To-Provider Network Registry Directory; 2) certify that the information provided on this form is correct to the best of your knowledge; and 3) give your permission to verify the above references.

Failure to provide all of the required information on this application will result in your application being denied. Once listed in our database, you will need to contact the Coalition with any address or telephone changes. We will contact you on a regular basis to update this information. Failure to respond to our update requests will result in removal from the database.

Submitting this application does not guarantee inclusion on the registry and/or a guarantee of use.

Signature

Date

Mail this form to: Foster & Adoptive Care Coalition
ATTN: Parent-to-Parent Network
111 N. 7th Street, Suite 402
St. Louis, MO 63101

Please contact Kimberly Knox, Director of Family Development, at 800.FOSTER.3 (314.367.8373) x35 or kimberlyknox@foster-adopt.org with any questions.

For Office Use Only: *Added to Register?* Yes No

If not added, why: _____

Folder ID Number: _____

REVIEWER SIGNATURE: _____ DATE: _____