

FOSTER HOME STATEMENT

Foster Parent's Name _____

Address _____

Signature _____

Child's Name	Begin Date	End Date	Total Days
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OFFICE USE ONLY			
Age	Rate	Amount	Total
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Begin Date: First day of the month or first day child stays in home.
 End Date: Last date of the month or last night child stays in home.
 (Board is paid for the day the child is placed in your home, but not for the day he leaves your home.)

Please have statements sent in by the 7th or the following month in order for bookkeeping to guarantee payment on time. – Thank you

THANK YOU FOR LENDING YOUR HEART AND HOME.

Columbiana county Department of Job & Family Services
 Children Services
 110 Nelson Street
 Lisbon, OH 44432
 (330) 424-7781 FAX (330) 424-0925

Attn: Jodi Routhieaux
 (eff. 1/1/11)

MONTHLY NOTES FROM FOSTER PARENTS

Child's name: _____

Month of: _____

Notes

My foster child's social worker visited on the following dates: _____

Foster parent: _____ Date: _____

(eff 1/1/11)

MONTHLY HEALTH ACTIVITY SHEET
 Please Submit With You Monthly Notes If Any
 Health Related Activities Occurred During The Month

Child's Name: _____ Case Number: _____
 Foster Parent/ Provider Name: _____

Treatment Type: Dental Medical Mental Vision Specialist

Full Name & Address of -Physician/ Hospital/ Provider: _____ Date of Appointment/s: _____

Type of Service:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> 30 day Healthcheck | <input type="checkbox"/> 60 day Healthcheck | <input type="checkbox"/> Annual Healthcheck | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Follow-up | <input type="checkbox"/> Non- Annual Physical | <input type="checkbox"/> Lab/ Testing |
| <input type="checkbox"/> Cleaning/ Exam | <input type="checkbox"/> Orthodontist | <input type="checkbox"/> Mental Assessment | <input type="checkbox"/> Diagnostic |
| <input type="checkbox"/> Eye Glasses/contacts | <input type="checkbox"/> Procedure/ Surgery | <input type="checkbox"/> Immunization | <input type="checkbox"/> Pre- Natal |
| <input type="checkbox"/> Other: Please specify _____ | | | |

Further Description if needed: _____

List Type/s - Illness, injury, testing, immunization (list each immunization separately):

Results of Appointment (Diagnosis/Prescriptions/What Doctor did)

Does the child have to go back for a follow-up visit? Yes No

If yes, Date of follow-up appointment/s: _____

Will transportation be needed? Yes No

Foster Parent/ Providers' Name: _____ Date: _____
 Case/Social Workers' Name: _____ Date: _____

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