

# TRACES

## Foster Care & Adoption

Dear Parents,

Thank you for your interest in the TRACES Program. Please find enclosed some program information and an application. We are excited about your interest in our program and welcome your questions.

If you feel that you are interested in applying, please complete the enclosed initial application and questionnaire and call or return the packet to us. We will schedule an office visit as soon as we hear from you. We look forward to guiding you through the wonderful world of fostering a deserving child.

Sincerely,

*Richard Rourke*

Richard Rourke  
TRACES Recruiter/Trainer  
423-224-1043 Office  
423-360-7902 Cell  
[rgrouk@frontierhealth.org](mailto:rgrouk@frontierhealth.org)

TRACES is a Therapeutic Foster Care Program to serve state custody children in the Eastern Grand Division of Tennessee. The program currently serves 95 children through a continuum of care. Each home will provide treatment for up to three children ranging from three to eighteen years of age and determined to have a priority need for therapeutic care by the State. The overall mission of the program is to re-educate and re-socialize each child so that the child can successfully be placed permanently in the community. Goals for each child include:

- ❖ Increasing the ability and skills needed to develop and participate in healthy relationships.
- ❖ Improving the ability to assess situations and solve problems while taking into account the need of others.
- ❖ Increasing self-esteem.
- ❖ Learning how to structure free time.
- ❖ Increasing independent living skills.
- ❖ Increasing rational thinking process.
- ❖ Learning how to control impulses.

Please feel free to call if you have any questions, concerns or desire more information. The TRACES staff of Frontier Health who provide training and 24-hour support for foster care families include: Division

Director Foster Care/Adoptions – Ashley Evans, MS, LPC/MHSP TRACES

Team Leader - Cindy Jenkins, BS TRACES

Parent Recruiter/Trainer – Richard Rourk, BS

Therapeutic Foster Care Specialists – Kara Coalson, Robin Henson, Jayne Merrill, Margaret Powers and Bailey Ward

Therapeutic Foster Care Therapist – Jeannie Childers

The role of the foster parent is pivotal in the treatment process. The foster family is ultimately responsible for coordinating the activities of the child, relationship building, day-to-day problem solving, transportation, implementation of the behavioral plan, as well as informal training in a wide array of independent living skills.

Each parent will receive approximately 60 hours of initial training and 15 hours annually of regularly scheduled on-going training during his/her participation in the program. Parents will meet each month with other trained parents for support and socialization. Parents will be reimbursed \$1,590.00 per month for each Level III, \$1290.00 per month for each level II child and \$690.00 per month for each level I child placed in their home.

We thank you for your interest in the TRACES Program. Our foster/adoptive parents are not only this programs' greatest asset but are a door to the future of our children.

Please feel free to call if you have any questions, concerns or desire more information.

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The TRACES staff of Frontier Health who provide training and 24 hour support for foster care families include:

**Division Director Foster Care/Adoptions** - Noelle Grimes, LPC

**TRACES Team Leader** - Cindy Jenkins, BS

**TRACES Parent Recruiter/Trainer** - Courtney Mauk, BA

**Therapeutic Foster Care Specialists** - Jayne Merrill, Kara Coalson, Margaret Powers, Paige Smith, Bailey Ward

**Therapeutic Foster Care Therapist** - Alexis Shepperd

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# TRACES Parent Application

Applicant \_\_\_\_\_  
(First) (Middle) (Last)

Co - Applicant \_\_\_\_\_  
(First) (Middle & Maiden) (Last)

Telephone #: (home) \_\_\_\_\_ (cell): \_\_\_\_\_

(work/emergency): \_\_\_\_\_

Social Security Number: (husband) \_\_\_\_\_ (wife) \_\_\_\_\_

Directions to your house: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Applicant's race: \_\_\_\_\_ Religion: \_\_\_\_\_

Date and Place of Birth: \_\_\_\_\_

Employer, Title and Hours: \_\_\_\_\_

Co-Applicant's race: \_\_\_\_\_ Religion: \_\_\_\_\_

Date and Place of Birth: \_\_\_\_\_

Employer, Title and Hours: \_\_\_\_\_

Date and Place of Marriage: \_\_\_\_\_

(Please attach a copy of your marriage certificate)

Previous Marriages: (Date/city/state) \_\_\_\_\_

(Please attach a copy of your divorce decree)

Have either spouse been employed by or applied for a job with Frontier Health (Watauga Mental Health - Central Appalachian Services - Nolachucky-Holston Area Mental Health) or Woodridge Hospital?

Yes \_\_\_ No \_\_\_ Applicant \_\_\_ Co-Applicant \_\_\_ Date Employed or Applied \_\_\_\_\_

Have either spouse received outpatient or inpatient treatment at Frontier Health (Watauga Mental Health - Central Appalachian Services - Nolachucky-Holston Area Mental Health) or Woodridge Hospital?

Yes \_\_\_ No \_\_\_ Applicant \_\_\_ Co-Applicant \_\_\_ Date(s) \_\_\_\_\_

Have either spouse served in the Military? Yes \_\_\_ No \_\_\_ If yes, specify applicant \_\_\_ co-applicant \_\_\_

Discharge date \_\_\_\_\_ Branch \_\_\_\_\_ Dates of service \_\_\_\_\_

Discharge status: \_\_\_\_\_ Honorable or Dishonorable (Circle one)

## TYPE OF CHILD YOU HOPE TO FOSTER/ ADOPT

Sex: Male Female Either Age Range: Youngest \_\_\_\_\_ Oldest \_\_\_\_\_

Sibling group: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many children would you consider fostering/adopting at this time? \_\_\_\_\_

### Legal:

Are you currently charged with or have you ever been convicted, placed on probation or received a suspended sentence for:

	Applicant	Co-Applicant
a. Any crime involving children?	Yes No	Yes No
b. Any crime of violence against another person	Yes No	Yes No
c. Possession, sale, manufacturing or transportation of drugs?	Yes No	Yes No
d. Any other crime? Explain	Yes No	Yes No

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Foster Parent Address List

\*\*\*Please list all addresses for the last five years beginning with your present address

(1) \_\_\_/\_\_\_/\_\_\_ to present

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(2) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(3) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(4) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(5) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(6) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

(7) \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ Street

\_\_\_\_\_ City State Zip

Please give **names, complete addresses, and telephone numbers** of individuals whom we may consult as result as a reference. Select those who know you as parents (such as neighbor, friend or someone from your child's school). Please include **one relative reference** per applicant and three non-relative references per applicant.

1) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

2) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

3) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

4) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

5) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

6) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

7) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

8) \_\_\_\_\_  
Name Relationship Street/ Apartment  
\_\_\_\_\_  
Telephone City State Zip Code

I give permission to those listed as references to answer questions about my parenting and my ability as a parent to care for special needs children and adolescents. I understand that this information is confidential and not available for my use.

Signed \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_



## Other Members of the Household

Name \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship \_\_\_\_\_

School/Grade(or employer) \_\_\_\_\_

Name \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship \_\_\_\_\_

School/Grade(or employer) \_\_\_\_\_

Name \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship \_\_\_\_\_

School/Grade(or employer) \_\_\_\_\_

Name \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship \_\_\_\_\_

School/Grade(or employer) \_\_\_\_\_

## Exclusionary Statement

I/We \_\_\_\_\_ understand that due to the nature of foster care service for children, commitment and consistency are critical. In order for TRACES staff to best serve their children, as well as their foster parents, any applicant must not be actively participating in any other foster care program. It is also understood that once we are accepted into the TRACES Program and are being considered for placement, we will not apply or accept placement from any other agency (i.e. Department of Children's Services, Department of Human Services, Omni Visions, Inc. Holston Home for Children, etc). We also understand and agree that our completed TRACES Foster / Adoptive home study will be placed in the Tennessee Department of Children's Services TFACTS System.

Please check your current foster parent status:

\_\_\_\_\_ I/We are currently not participating in any foster care program.

\_\_\_\_\_ I/We are approved for fostering with another agency but do not have a child in placement. (Please name agency and enclose a letter of resignation)

\_\_\_\_\_ I/We currently have a foster child placed by another agency. (Only if the plan has already been made for child to be moved, please enclose a letter of resignation after talking with us. We do not encourage **any** foster care disruptions).

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_



