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| http://intranet.dcyf.wa.gov:8090/drupal-8.4.0/sites/default/files/graphics/DCYF-Logo-BW.jpg | LICENSING DIVISION (LD)**Applicant Mental Health Report****CONFIDENTIAL** |  |
| DATE  |
| **Section 1: Completed by applicant. Return to local Licensing Division office.**  |
| MENTAL HEALTH PROVIDER | PHONE AND FAX NUMBER (AREA CODE) | LOCAL LICENSING DIVISION OFFICE |
| ADDRESS NAME/LOCATION |
| CITY | STATE | ZIP CODE |
| APPLICANT NAME | DATE OF BIRTH |
|  I hereby authorize my mental health provider to release information including, but not limited to, mental health history, diagnosis and prognosis. This information is required as part of a home study for foster care and/or adoption. This release of information is valid for one year from the date of my signature.  |
|  |   |  |
|  SIGNATURE OF APPLICANT DATE |
| **Section 2: Completed by Mental Health Provider. Return to local Licensing Division office listed above.** |
| DATE FIRST SEEN BY PROVIDER | DATE OF LAST APPOINTMENT |
| FREQUENCY OF VISITS |

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| PAST MENTAL HEALTH DIAGNOSES |

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| CURRENT MENTAL HEALTH DIAGNOSE |

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| DESCRIBE STABILITY OF APPLICANT |

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| CURRENT MEDICATIONS: PLEASE STATE THE PURPOSE OF THE MEDICATION, PROBLEMS THAT MIGHT OCCUR IF MEDICATION IS NOT TAKEN AS PRESCRIBED, AND HOW IT AFFECTS DAILY FUNCTIONING (PARTICULARLY WITH REGARDS TO SAFETY OF DRIVING, ALERTNESS, AND ABILITY TO SAFELY SUPERVISE CHILDREN). PLEASE COMMENT ABOUT ANY CONCERNS REGARDING HOW THE COMBINATION OF MEDICATIONS THAT THE APPLICANT TAKES MIGHT AFFECT FUNCTIONING. |

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| PLEASE DESCRIBE HOW ANY MENTAL HEALTH CONDITION AFFECTS THE CARE OF ADDITIONAL CHILDREN IN THE HOUSEHOLD. |

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| CONCERNS, COMMENTS, OR IMPRESSIONS |

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| MENTAL HEALTH PROVIDER SIGNATURE | PRINT NAME | DATE |