 **Only use arrow down/up keys to navigate. Do not use tab key.**

**CWL-4627, Add an Adult Household Member Addendum**

Michigan Department of Health and Human Services (MDHHS)

Division of Child Welfare Licensing (DCWL)

(New 5-25)

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**section 1**

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| Provider Name | License Number |

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| Terms of license (capacity and age range) |

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| Number of Adult household members being added |

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| Relation to Application |

**SECTION 2 – CLEARANCES**

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| Verification of review of DCWL Central Record Clearances |
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| **Is name on** Public Sex Offender Registry (PSOR)? | **[ ]  Yes [ ]  No** |

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| If yes, explain |

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| Central Registry/Child Protective Services (CPS) history | **[ ]  Yes [ ]  No** |

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| If yes, explain |

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| Result of ICHAT check |
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| If there are any criminal convictions, explain |
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| **Is an ART report needed?** | **[ ]  Yes [ ]  No** |

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| **Has AHHM resided out of state in the past five years?** | **[ ]  Yes [ ]  No** |

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| If yes, list state(s) resided in, and date Adam Walsh checks were completed (results must be uploaded). |

**section 3 – social history**

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| Family of origin description, including Number of siblings, parents’ roles, personalities, expectations, parenting involvement, discipline styles, family celebrations, values. |

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| Parents’ substance uses and how it affected the family, lasting impact on individual. |

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| Previous incidents of domestic violence, elder abuse, or child abuse, either as a perpetrator or victim. |

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| How family dealt with any abuse/victimization, continuing impact on individual. Is perpetrator still involved in the family dynamics (if applicable)? |

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| The willingness to provide substitute care, if appropriate, or be involved with the foster/adopted children who may be placed in the home. |

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| Their opinion of the applicant’s parenting skills and desire to foster/adopt children. |

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**SECTION 4 – HEALTH**

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| **Is Medical Statement available?** | **[ ]  Yes [ ]  No** |

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| If No, per Rule 9206, c, iii a medical statement must be provided within 90 days): outline family’s plan to complete within 90 days. |

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| Medical Conditions |
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| Mental Health Diagnosis or Substance Abuse Issues |
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| Prescribed Medications |
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| Any special care considerations? |
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**SECTION 5 – HOUSEHOLD SLEEPING ARRANGEMENTS**

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| Household Sleeping Arrangements |
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**section 6 – signatures**

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| Licensing Worker Signature→ | Date |
| Licensing Supervisor Signature→ | Date |

**(Do not type beyond this point)**

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**End of form**