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|  | LICENSING DIVISION (LD)  **File Checklist (Kinship License)** | | | |
| APPLICANT / PROVIDER NAME | | | PROVIDER NUMBER | |
| ADDRESS | | CITY | STATE  **, WA** | ZIP CODE |
| **I have verified the following requirements:** | | | | |
| TB screening (including negative TB test or documentation from a licensed medical provider where indicated) for all adults in home. | | | Yes  N/A  Waiver  Non-Safety Exemption | |
| Vaccine Exemption (DCYF 15-455) verified for all child household members needing a vaccine exemption. | | | Yes  N/A  Waiver  Non-Safety Exemption | |
| Pertussis vaccine (per agreement) and/or Vaccine Exemption (DCYF 15-455) verified for all adult household members (if caring for children under the age of 2 years or medically fragile children). | | | Yes  N/A  Waiver  Non-Safety Exemption | |
| Influenza vaccine (per agreement) and/or Vaccine Exemption (DCYF 15-455) verified for all household members. | | | Yes  N/A  Waiver  Non-Safety Exemption | |
| Cleared well test for private water. | | | Yes  N/A  Waiver  Non-Safety Exemption  Compliance Agreement | |
| At least one applicant is a member or eligible for membership as determined by a federally recognized tribe per RCW 13.38.040(12) (verification has been reviewed by any means, upload not required). | | | Yes  N/A | |
| All applicants were provided an opportunity to review the Notice of Nondiscrimination publication (HR\_0012). | | | Yes  Other  **\_\_\_\_\_** | |
| Background check completed for all household members ages 16 & 17. | | | Yes  N/A | |
| FamLink check completed for all household members under the age of 18. | | | Yes  N/A | |
| Open investigations. | | | None  Other  **\_\_\_\_\_** | |
| Pending Compliance Agreements (DCYF 10-248) | | | None  Provider agrees to sign a Compliance Agreement related to  **\_\_\_\_\_** | |
| This home study includes adoption. | | | Yes  No  N/A | |
| **I have verified the following adoption requirements:** | | | | |
| Marriage and/or divorce decrees and/or death certificates. | | | Yes  N/A | |
| Income verification. | | | Yes  N/A | |
| Applicant Medical Report (DCYF 13-001) completed by medical provider. | | | Yes  N/A | |
| **Additional Comments** | | | | |

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| **LD/CPA Staff Signatures** | |
| LD/CPA STAFF NAME | LD/CPA SUPERVISOR NAME |
| LD/CPA STAFF SIGNATURE DATE | LD/CPA SUPERVISOR SIGNATURE DATE |