

FOSTER PRIDE/ADOPT PRIDE PRE-SERVICE TRAINING REFERRAL FORM

Participants must be referred to attend Foster PRIDE/Adopt PRIDE Pre-Service training by an agency worker. This form is NOT to be filled out by the participants. Call 877/800-3393 if you have questions. The participants will receive a confirmation letter from the DCFS Registration Unit with the class information. Agency workers who provide an email address will receive an electronic copy of participant confirmation letters. **FAX completed referral form to the DCFS Office of Training at 217/557-4349.**

1st Choice Training Date _____ **First Class Available** _____ **Location/City** _____

2nd Choice Training Date _____ **Location/City** _____

Please check to indicate if completed:

- Applicants have been given Foster Parent Application Form
- Applicants know the name of their Family Development Specialist/Licensing Representative
- First home visit was completed by a Family Development Specialist/Licensing Worker Date: _____

Please Note: If these three steps have not occurred, applicants are not ready to be referred to PRIDE Training.

CHECK BOXES THAT APPLY: **Unrelated Foster Parent** **Related Foster Parent** **SPANISH Speaking Family**
 DCFS **POS** **Other** _____

Please print

Parent (#1) Name Mr./Mrs./Ms. (Last) _____ (First) _____

Social Security Number #1 _____ **Work Phone #** _____
(social security required and will be kept confidential)

Home Phone # _____ **Cell Phone #** _____

Home Address _____

City _____, Illinois **Zip** _____

E-Mail Address _____ (If no home e-mail – please write “none”)

Type of Internet Connection: Dial-Up DSL Cable Satellite Network email access through employment

Special Needs (Parent #1): Vision Hearing Other _____

Parent (#2) Name Mr./Mrs./Ms. (Last) _____ (First) _____

Social Security Number #2 _____ **Work Phone #** _____
(social security required and will be kept confidential)

Cell Phone # _____

E-Mail Address _____ (If no home e-mail – please write “none”)

Type of Internet Connection: Dial-Up DSL Cable Satellite Network email access through employment

Special Needs (Parent #2): Vision Hearing Other _____

Agency Worker Name (please print) _____

First Name

Last Name

Agency Name _____ **E-Mail** _____

Please include work e-mail address to receive a copy of Adoption Training confirmation letter from DCFS Registration Unit

Agency Address _____ **City** _____ **Zip** _____

Telephone # _____ **SIGNATURE** _____ **Date** _____