



CHRISTIAN FAMILY CARE
Serving Children and Families Since 1982

Safe Families for Children

602-234-1935 • 3603 N. 7th Avenue, Phoenix, AZ 85013
520-296-8255 • 6063 E. Grant Road, Tucson, AZ 85712

Acknowledgement of Safe Families for Children Policy

When a child is placed by one parent or guardian without the signed consent of another who has custodial rights Safe Families for Children requires this signed acknowledgment of Safe Families for Children policies.

1. Safe Families for Children (SFFC) will host children based on the signed consent of any one person who has custodial rights.
2. SFFC will not disclose information about hosting arrangement to individuals unless SFFC determines that they have a right to the information.
3. Persons who have a right to information include, but are not limited to:
 - a. Biological parents upon proof of parentage.
 - b. Representatives of any government agency, including social services or state child welfare agencies.
 - c. Law enforcement officials.
 - d. Court officials.
 - e. Medical personal when the information is related to medical treatment.
 - f. Parties with valid court orders requiring the disclosure of information.
4. SFFC will not participate in or allow any attempt to make misrepresentations to anyone, including but not limited to, the entities listed in section 3. If SFFC becomes aware of any such misrepresentations it will take action to correct the mistaken information even if the parties involved are not described in section 3.
5. SFFC advises those who participate in the program that the best course of action is full disclosure to court and government officials. Failure to provide such disclosure may jeopardize custody rights and lead to criminal or civil liability.

I have read, understand, and agree to the policy stated above.

Signature

Print Name

Date



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Arizona Medical
 For health care of a minor dependent Pursuant to

I. My/our child is _____ born on _____.

I/we (Parent/Legal Guardian), * _____, hereby appoint (Safe Family for Children Hosts) _____, as my attorney-in-fact (my "agent" to act for me and in my name in any way I could act in person) to make any and all decisions for me/us concerning my/our child's personal care, medical treatment; including but not limited to routine and ordinary care, evaluation, treatment, including diagnostic evaluations of any sort, including invasive and non-invasive procedures to the extent customarily used (of an emergency or non-emergency nature), including in-patient or out-patient hospitalization and all other health care and to require, withhold or withdraw any type of medical treatment or procedure as I/we would want to require, withhold or withdraw for my/our child if I could act in person. My/our agent shall have the same access to medical records that I have, including the right to disclose the contents to others.

Biological Parent/Legal Guardian: * _____; Additional Biological Parent/Legal Guardian: * _____
 (Initial) (Initial)

I/we specifically acknowledge and authorize my/our appointed agent _____ (Safe Family Parent(s)) to assume the following medical care rights and responsibilities:

A. Physical Examination

I/We authorize my/our appointed agent (Safe Family Parent(s)) to consent to and obtain a physical examination for my/our child.

B. Routine and Ordinary Medical Care

I/We authorize my/our appointed agent (Safe Family Parent(s)) to consent to and obtain any routine or ordinary medical care for my child including inoculations and immunizations. I/We also understand that staff will make a reasonable effort to contact me/us prior to such care but that failure to contact me/us will not be a reason to not obtain care for my/our child.

C. Diagnosis and Treatment

I/we authorize my/our appointed agent (Safe Family Parent(s)) to consent to and obtain diagnosis and treatment for my /our child(ren), whether invasive or non-invasive, as is deemed necessary and appropriate to prevent or care for any medical condition my child is reasonably believed to have or to alleviate my/our child's pain and suffering.

D. Extraordinary Medical Care

I/We authorize my/our appointed agent (Safe Family Parent(s)) to consent to and obtain any extraordinary medical care for my/our child including hospitalization, blood transfusion, surgery, and treatment in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. I/we also understand that staff will make a reasonable effort to contact me/us prior to such care, but that failure to contact me/us will not be reason to deny treatment to my/our child.

E. Medical Card or Private Medical Insurance

If my/our child has a Medical/Medicare card, I/we agree to give my/our appointed agent (Safe Family Parent(s)) the current care and will continue to provide the current care throughout the child's stay. If my/our child has a private medical insurance, I/we will give my/our appointed (Safe Family Parent(s)) a copy of my/our insurance card and other pertinent information regarding the medical; insurance and to pay any copayments or other charges not covered by the medical insurance. If my/our child is not covered under insurance plan either private or public, I/we agree to pay for any and all medical care that is required for my/our child.

Applicable provider: _____ and card number _____

I/we agree to pay uncovered charges: * _____

2. I/we direct my appointed agent (*Safe Family for Children Hosts*) to take such action on behalf of my child as is reasonable or necessary to alleviate suffering and to authorize any treatments as to which the potential and expected benefits outweigh the potential and expected burdens.

Biological Parent/Legal guardian:* _____; Additional Biological Parent/Legal Guardian:* _____
(Initial) (Initial)

3. I/we want my child's life prolonged and I /We want life-sustaining treatment to be provided to my child unless the child is in a coma which the child's attending physician believes to be irreversible. In accordance with reasonable medical standards at the time of reference. If and when my/our child suffers an irreversible coma, I/we want life-sustaining treatment to be withheld or discontinued. _____
(Initial)

Biological Parent/Legal guardian:* _____; Additional Biological Parent/Legal Guardian:* _____
(Initial) (Initial)

4. This power of attorney shall become effective on _____.
5. This power of attorney shall terminate when my chld(ren) have been removed from the SFFC program.
6. I/we nominate as my/our agent (*Safe Family Parent(s)*) _____.

7. If any agent named by me/us shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable; I/we name the following as successors to such agent: CFC Treatment Centers.
8. If a guardian of my child(ren) is to be appointed, I/we nominate the agent acting under this power of attorney as such guardian, to serve without bond of security.
9. I/we am/are fully informed as to all the contents of this form and understand the full importance of the grant of powers to my/our appointed agent (*Safe Family Parent(s)*).

Biological Parent/Legal Guardian Signature* (Date) Additional Biological Parent/Legal Guardian Signature* (Date)

Witness Name Printed Witness Name Signature (Date)

Required documentation to be completed by:

***Biological Parent(s)/Legal Guardian:**

- #1 (initials) #3 (initials)
- #2 1-E (signature/date) #9 1-E (signature/date)
- #2 (initials)

Safe Family Parent(s indicated):

#1 (x2); #6

Fax All placement documents to 602-234-0022 Copy of document provided to parent/legal guardian and Safe Family for Children Hosts; with original placed into CFC Safe Family for Children Child File.



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PLACEMENT AGREEMENT
Between Safe Family Parent and Biological Parent/Guardian

Name of child	Date of Birth:	Name of child:	Date of Birth:
1.		4.	
2.		5.	
3.		6.	

Biological Parent or Legal Guardian: _____

I, _____ hereby agree to temporarily place my child(ren) with
_____ (Safe Family Parent(s))

I hereby authorize the Safe Family Parent to administer prescriptions and non-prescription medications to my child as medically necessary. I also give my permission to contact a doctor for medical attention in the event of an emergency. It is understood that a conscientious effort will be made to contact me or a designated emergency contact or a representative before any action will be taken.

- I hereby give the Safe Family Parents permission to discipline the above named child in a firm and consistent manner, utilizing individual talks, removal of privileges, or any other non-physical punishment appropriate for his/her developmental level. Spanking or any other forms of physical punishment are not allowed at any time.
- I understand that I maintain full and complete custody of my child and that I can pick my child up from the Safe Family at any time.
- I pledge to use this time as a valuable resource to pursue personal growth, resolve the circumstances and/or any personal factors leading to this time of crisis, and the attainment of the goals I have set for providing a stable and healthy home to bring my child(ren) back into.
- I understand that Safe Families, CFC, and Safe Family Parents cannot guarantee the safety of the child(ren) I have placed in the Safe Families for Children Program, myself, or anyone in my family. I agree to assume any risks associated with my child staying with this Safe Family because I see the benefits of the Safe Family Program, and because I understand Safe Families, CFC, and Safe Family Parents are offering this service to me out of a spirit of generosity and compassion.
- I agree that I will not hold Safe Families, CFC, or Safe Family Parents responsible for any injuries or losses of any kind that the children may suffer or incur as a result of their placement in the Safe Families Program or during the child(ren)'s stay with the Safe Family.

(Signature of Biological parent or Legal Guardian)

(Print First and Last Name)

(Date)



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Waiver of Liability, Assumption of Risk, and Indemnity Agreement

Name of Parent or Legal Guardian: _____

Name of Participating Child: _____

Date of Birth: _____

Today's Date: _____

Assumption of Risks: Participation in Safe Families for Children ("Safe Families") carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains; 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to; 3) catastrophic injuries including paralysis and death.

I, FOR MYSELF, MY HEIRS, PERSONAL REPRESENTATIVES OR ASSIGNS VOLUNTARILY ASSUME ALL RISK, KNOWN AND UNKNOWN, OF INJURIES, HOWEVER CAUSED, EVEN IF CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF SAFE FAMILIES, CFC OR THE FAMILY THAT IS CARING FOR THE CHILD PLACED WITHIN THE SAFE FAMILIES PROGRAM, THEIR OFFICERS, EMPLOYEES, VOLUNTEERS AND AGENTS.

Waiver: Knowing and understanding the risks described above, and in consideration of being permitted to participate in Safe Families' child placement program, I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, and discharge Safe Families, CFC, and the family that is caring for the child placed within the Safe Families program**, their officers, employees, volunteers and agents from any claim that I may have for any losses, damages, legal expenses including attorneys' fees, or injuries that may arise out of or in connection with participation in Safe Families, **including injuries resulting from the negligence of Safe Families, CFC or the family that is caring for the child placed within the Safe Families program, its officers, employees and agents.**

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in Safe Families. I hereby assert that my participation is voluntary and that I knowingly assume all such risks. (_____) (Initial)

Indemnification and Hold Harmless: I also agree to INDEMNIFY AND HOLD Safe Families, CFC and the family that is caring for the child placed within the Safe Families Program HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in Safe Families and to reimburse them for any such expenses incurred. (_____) (Initial)

Severability: I, for myself, my heirs, personal representatives or assigns, expressly agree that the foregoing Waiver and Assumption of Risk Agreement is intended to be as broad and inclusive as is permitted by the law of the State of Arizona and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Acknowledgment of Understanding: I have read this Waiver of Liability, Assumption of Risk, and Indemnity Agreement, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

I, the Program Participant, have read, understood and agree to each of the preceding paragraphs.

 Print Parent or Guardian Name

 Parent or Guardian Signature

 Date:



Safe Families *for* Children

3603 N. 7th Avenue
Phoenix, AZ 85338
602-396-2720 – main office
602-234-0022 – fax

I, _____, parent of
_____, born on _____

am taking my child today from placement with _____
(Safe Family parents) through Safe Families for Children where he/she was placed at my request on
_____.

I have received him/her in good health and I release _____ (Safe
Family parents) and Christian Family Care from any further responsibility for his/her care.

Signature of Parent or Guardian

Date

Witness

Date

Safe Families for Children
Christian Family Care
3603 N. 7th Avenue
Phoenix, AZ 85013
602-234-1935

Safe Families Program: Parent Information

Your Name: _____ Date of Birth: _____ Date _____

Child/Children

Name _____ Age _____ Sex _____ Grade _____

Parents or Legal Guardians of Children

Father _____ Home Phone _____

Address _____ City/State/ZIP _____

Employer _____ Occupation _____

Work Phone _____ Other phone _____ pager
 cellular

Mother _____ Home Phone _____

Address _____ City/State/ZIP _____

Employer _____ Occupation _____

Work Phone _____ Other phone _____ pager
 cellular

Parents' marital status: married separated divorced Other _____

Legal guardian(s) (if not parents) _____ Phone _____

Address _____ City/State/ZIP _____

In case of emergency, who should be notified first? Mother Father Other _____

Medical Child's physician, or, if applicable, Certified Christian Science Practitioner

Name _____ Phone _____

Address _____ City/State/ZIP _____

Prescribed Medication _____

Significant Illnesses or concerns

Authorized Individuals for Drop-Off and Pick-Up of Child; besides birth parents. These following individuals (other than parents or guardians) are willing to accept responsibility for the child and should be contacted if the parents or guardians cannot be reached.

Name _____ Relationship _____

Phone _____ Address _____

What is your reason for seeking temporary placement of your child(ren) through the Safe Families Program?

What are your goals to attain to be able to bring your child back into a healthy, stable home environment?

How long do you think it will take you to meet this goal?

Have you ever been involved with DES? ___ Yes ___ No Please explain _____

Have you ever been in drug or alcohol treatment? ___ Yes ___ No Please Explain _____

Have you ever been homeless in the past? ___ Yes ___ No Please Explain _____

Have you even been in need of domestic violence services? ___ Yes ___ No Please Explain _____

Have you ever been charged with a crime? ___ Yes ___ No if yes, were you convicted? ___ Yes ___ No

Please describe the circumstances _____

Have you ever been incarcerated? ___ Yes ___ No Please Explain _____

What are the current services you are receiving? _____

Are there other services or needs that you have? _____

Do you have any health concerns that need attention? _____

Are you currently on any medication? _____

Mother's Background

Who is in your family? _____

Parent's current status (retired, etc.) _____

Parenting style/discipline/rules _____

Educational experience _____

Current/past medical history _____

Your Strengths/special skills _____

Your Weaknesses/problems _____

Father's Background

Who is in father's family? _____

Parenting style/discipline/rules _____

Educational experience _____

Current/past medical history _____

Strengths/special skills _____

Weaknesses/problems _____

Resources

Are there any extended family members living in the area? _____

Do you have other close friends or neighbors? _____

I have had these experiences (Please Circle): Rape Sexual Abuse Physical Abuse

Domestic Violence Homelessness Suicidal thoughts Victim of crime

Used Drugs Mental Health Counseling Financial Problems Abused Alcohol

I have the following needs (please circle): Job stable home counseling

spiritual support Help with my children Training in parenting Marriage Counseling

Addictions/recovery support other: _____

I struggle with these emotions (please circle): sadness loneliness depression

nervousness fears Anxiety Anger Guilt Emptiness

hopelessness helplessness

Parent Signature and Date

Safe Families Staff's Comments: Acceptance? ___ yes ___ no Explain:

Staff's Impressions: _____

Service Recommendations: _____

Staff's Signature and Date



POWER OF ATTORNEY OVER A MINOR

YOU CAN USE THIS FORM IF THESE ARE TRUE:

1. You want to give another adult person temporary authority over your child.
2. That adult person agrees.

INSTRUCTIONS

A parent signs a Power of Attorney in front of a notary to give non-parent authority temporary parental control of their child(ren). Power of Attorney is not a court order. It may not be used to authorize another person to consent to your child's marriage or adoption. A Power of Attorney expires after maximum of six months. If you want another Power of Attorney after six months, you may sign a new one. You may cancel, or "revoke," the Power of Attorney at any time.

STEP 1: FILL OUT THE POWER OF ATTORNEY OVER A MINOR CHILD

1. Enter your name and address.
2. Complete a separate form for each child (with their name and birthdate) you want covered by Power of Attorney.
3. Enter the name and address of the adult person you want to have power of attorney.
4. Check the box indicating whether you want to give that person full parental responsibility or only specific responsibilities. If you check "specific parental responsibilities," list them.
5. Enter the date when the Power of Attorney will begin. Enter the date, *not more than six months later*, when it will end. ***Any ending date longer than six months will be interpreted as six months exactly.***
6. Read the Power of Attorney and make sure that you understand everything in it and that everything in it is true. Do not sign until you're in front of a notary.
7. Enter the witness's name. The witness also must wait to sign until you're in front of a notary. The witness may not be the person you want to have power of attorney or that person's spouse or child.

STEP 2: SIGN THE POWER OF ATTORNEY IN FRONT OF A NOTARY

Take the following to a notary:

- The witness as described above.
- The original and one copy of the Power of Attorney Over a Minor Child form.
- Photo ID for the witness and yourself.

Most banks have Notaries and often do not charge their customers with accounts. There are Notaries in various businesses and others are listed in the Yellow Pages. These "public" Notaries typically charge a fee. The person signing must bring photo ID. Sign the original and the copy of the Power of Attorney in front of the notary and have the witness also sign in front of the notary.

STEP 3: GIVE ONE ORIGINAL SIGNED POWER OF ATTORNEY TO THE OTHER PERSON

Keep the other signed Power of Attorney for your records.

STEP 4: MAKE COPIES OF THE POWER OF ATTORNEY

Make copies of the Power of Attorney for each person or organization you deal with on behalf of the child. Show them the original, and give them the copy.

POWER OF ATTORNEY OVER A MINOR CHILD
A.R.S. 14-5104

1. My Name: _____

My Address: _____

I am the natural parent of the following child:

2. Child's Name:

Birthdate:

_____	_____
_____	_____
_____	_____
_____	_____

A.R.S 14-5104: Delegation of powers by parent or guardian

A parent or a guardian of a minor or incapacitated person, by a properly executed power of attorney, may delegate to another person, for a period not exceeding six months, any powers he may have regarding care, custody or property of the minor child or ward, except power to consent to marriage or adoption of the minor.

I authorize the following person to assume power of attorney over my child listed above, in accordance with A.R.S. 14-5104.

3. Name of Person Authorized: _____

Address of Person Authorized: _____

4. I further appoint the person named above as my true and lawful attorney for the purpose of performing the following responsibilities over my child listed above.

All parental responsibilities I might perform myself.

Only the following specific parental responsibilities:

Giving or refusing consent to any medical treatment, including x-ray examination, anesthetic, medical or surgical diagnosis and treatment, hospital admission, or other related health care needs;

5. This Power of Attorney will begin on _____ and expire, *not more than six months later*, on _____, unless I revoke it earlier.

6. I, the principal, sign my name to this power of attorney, and, being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, that I execute it as my free and voluntary act for the purposes expressed in it and that I am at least 18 years old, of sound mind, and under no constraint or undue influence.

Parent's Signature: _____

State of Arizona)

)

County of _____)

Subscribed and sworn before me this date: _____ by: _____

Seal: Notary Public: _____

Notary Expiration Date: _____

7. Witness's Name: _____

I, the witness, sign my name to the foregoing power of attorney being first duly sworn and do declare to the undersigned authority that the principal signs and executes this instrument as his/her power of attorney and that he/she signs it willingly and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is at least 18 years old, of sound mind, and under no constraint or undue influence.

Witness's Signature: _____

State of Arizona)

)

County of _____)

Subscribed and sworn before me this date: _____ by: _____

Seal: Notary Public: _____

Notary Expiration Date: _____