## ERMA'S HOUSE APPLICATION SUPERVISED PARENTING TIME/VISITATION

Please complete this application and mail it to Erma's House Visitation Center, 1046 Brown Street, Dayton, Ohio 45409.

After applications have been received from **BOTH** the custodial <u>and</u> non-custodial party Erma's House staff will contact you to schedule an intake interview.

PLEASE PRINT	DATE:	
REFERRED BY:		
☐ JUVENILE COURT ☐ DOMESTIC RELATIONS COURT	☐ CHILDREN'S SERVICES	
□ OTHER		
<b>Name</b> (S):	☐ CUSTODIAL ☐ NON-CUSTODIAL	
☐ MOTHER ☐ FATHER ☐ LEGAL GUARDIAN ☐ FOST	TER PARENT   OTHER	
DATE OF BIRTH:	AGE:	
<b>GENDER:</b> □ MALE □ FEMALE □ TRANSGENDER	□ Non-Binary	
CURRENT ADDRESS: STREET	CITY ZIP CODE	
TELEPHONE NUMBER:		
ALTERNATE TELEPHONE NUMBER:	□ Home □ Cell	
BEST TIME TO CONTACT YOU:		
EMPLOYMENT:	JOB TITLE:	
MODEL OF CAR:	LICENSE PLATE NUMBER:	
DEMOGRAPHIC INFORMATION  MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW(ER) SEPARATED		
RACE OR ETHNIC GROUP:   BLACK/ AFRICAN AMERICAN   AMERICAN INDIAN/ALASKAN NAT  OTHER (PLEASE SPECIFY)	IVE   Native Hawaiian/Other Pacific Islander	
EDUCATION COMPLETED:	GROSS ANNUAL INCOME:	
COUNTY OF RESIDENCE:		
(Please Circle) Health Insurance: Private/ Public Medicaid/ Public Medicare & Medicaid/ Both Public/Private -or- Uninsured		

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## PLEASE LIST ALL CHILDREN LIVING IN THE HOME PARTICIPATING IN SUPERVISED VISITATION.

CHILD 1           FIRST NAME:		
GENDER:   MALE   FEMALE   TRANSGENDER   NON-BINARY		
DATE OF BIRTH: RACE OR ETHNIC GROUP:   BLACK/ AFRICAN AMERICAN  ASIAN  MULTI-RACIAL  WHITE  HISPANIC/ LATINO		
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER		
□ OTHER (PLEASE SPECIFY)		
(PLEASE CIRCLE) HEALTH INSURANCE: PRIVATE/ PUBLIC MEDICAID/ PUBLIC MEDICARE & MEDICAID/ BOTH PUBLIC/PRIVATE -OR-		
Uninsured		
CHILD 2		
FIRST NAME: LAST NAME:		
GENDER:   MALE   FEMALE   TRANSGENDER   NON-BINARY   DATE OF BIRTH:		
RACE OR ETHNIC GROUP:  BLACK/ AFRICAN AMERICAN  ASIAN  MULTI-RACIAL  WHITE  HISPANIC/ LATINO		
☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER		
OTHER (PLEASE SPECIFY)		
(PLEASE CIRCLE) HEALTH INSURANCE: PRIVATE/ PUBLIC MEDICAID/ PUBLIC MEDICARE & MEDICAID/ BOTH PUBLIC/PRIVATE -OR-		
Uninsured		
CHILD 3		
FIRST NAME:LAST NAME:		
GENDER:   MALE   FEMALE   TRANSGENDER   NON-BINARY   DATE OF BIRTH:		
RACE OR ETHNIC GROUP   BLACK/ AFRICAN AMERICAN   ASIAN   MULTI-RACIAL   WHITE   HISPANIC/ LATINO		
AMERICAN INDIAN/ALASKAN NATIVE NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER  OTHER (Please specify)		
(PLEASE CIRCLE)		
HEALTH INSURANCE: PRIVATE/ PUBLIC MEDICAID/ PUBLIC MEDICARE & MEDICAID/ BOTH PUBLIC/PRIVATE -OR-		
Uninsured		
CHILD 4		
FIRST NAME:LAST NAME:		
GENDER:   MALE   FEMALE   TRANSGENDER   NON-BINARY   DATE OF BIRTH:		
RACE OR ETHNIC GROUP: Black/ African American Asian Multi-Racial White Hispanic/ Latino		
AMERICAN INDIAN/ALASKAN NATIVE   NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER		
□ OTHER (PLEASE SPECIFY)		
(PLEASE CIRCLE) HEALTH INSURANCE: PRIVATE/ PUBLIC MEDICAID/ PUBLIC MEDICARE & MEDICAID/ BOTH PUBLIC/PRIVATE -OR-		
Uninsured		

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## PLEASE LIST ADDITIONAL CHILDREN ON THE BACK IF MORE THAN FOUR CHILDREN WILL BE PARTICIPATING IN SUPERVISED PARENTING TIME.

PLEASE DESCRIBE YOUR CURRENT PARENTING TIME/VISITATION:	
HAVE THERE BEEN PROBLEMS WITH THE CURRENT	Γ ARRANGEMENT?
LIST POSSIBLE TIMES AND DAYS FOR SUPERVISED	PARENTING TIME/VISITATION:
ARE YOU CONCERNED ABOUT THE CHILD'S INVOLV	/EMENT IN SUPERVISED PARENTING TIME/VISITATION?
DO YOU HAVE ANY ADDITIONAL INFORMATION YOU	WOULD LIKE US TO KNOW?
PLEASE INDICATE YOUR PREFERENCES CONCERNI	ING THE FOLLOWING:
FOOD FOR CHILD DURING PARENTING TIME/VISIT:	□YES □No
GIFTS FOR CHILD DURING PARENTING TIME/VISIT (T	THAT CHILD WILL TAKE HOME): ☐ YES ☐ NO
Ем	ERGENCY CONTACT:
NAME:	RELATIONSHIP:
TELEPHONE NUMBER:	□ HOME □ CELL
ALTERNATE TELEPHONE NUMBER:	□ HOME □ CELL
PLEASE SIGN AND DATE THIS APPLICATION:	
SIGNATURE	 Date

## PLEASE PROVIDE THE FOLLOWING INFORMATION:

DO YOU HAVE AN ATTORNEY REPRESENTING YOU?	□YES □NO
Name:	TELEPHONE NUMBER:
Address:	
DOES YOUR CHILD(REN) HAVE A CASA OR GUARDIAN	N AD LITEM? ☐ YES ☐ NO
Name:	TELEPHONE NUMBER:
Address:	
DO YOU HAVE A CHILDREN'S SERVICES CASEWORKER	R? □YES □NO
Name:	TELEPHONE NUMBER:
Address:	
DO YOU HAVE AN UPCOMING HEARING?	□ No
DATE:	
COURT JUDGE OR MACISTRATE:	

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