

**THERAPEUTIC FOSTER FAMILIES
SERVICE SYSTEM SURVEY**

7. **What type(s) of post-licensing training(s) do you believe would be helpful to you as a foster parent?**
8. **Describe the adequacy of the support you receive from DCF. Set forth any successes and challenges.**
9. **Describe the adequacy of the support you receive from your therapeutic foster care agency. Set forth any successes and challenges.**
10. **What supports do you receive to facilitate foster children's contact with their biological families?**
11. **Please describe your overall experience of being a therapeutic foster parent. Let us know what factors, both positive and negative, that have impacted that experience.**
12. **Please check all the services/supports in which you and/or foster children in your care have accessed in the past year:**
- | | | |
|--|--|--|
| <input type="checkbox"/> Emergency Mobile Psychiatric Services | <input type="checkbox"/> Child Guidance Clinic | <input type="checkbox"/> Extended Day Treatment |
| <input type="checkbox"/> Intensive In-home Services | <input type="checkbox"/> Respite | <input type="checkbox"/> Systems of Care Community Collaboratives |
| <input type="checkbox"/> Foster Parent Liaison | <input type="checkbox"/> Family Advocate | <input type="checkbox"/> CT Association of Foster and Adoptive Parents |
| <input type="checkbox"/> FAVOR | <input type="checkbox"/> Mentoring | <input type="checkbox"/> 1:1 Support |

Please forward your completed survey by **December 21, 2007** to:
Mary Miller
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