IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
STEVEN L. MILLWARD– MANAGER
CERTIFIED FAMILY HOME PROGRAM
1720 Westgate Dr., Ste. B
Boise, ID 83704
PHONE (208) 334-0706
FAX (208) 239-6250
www.cfh.dhw.idaho.gov

CERTIFIED FAMILY HOME APPLICATION

www.cfh.dhw.idaho.gov

Please fill out this application **completely**.

APPLICANT INFORMATION: *please print*

Legal Name (First, Middle, Last): _____ Date of Birth: _____

Other Names Used: _____

Legal Name of person needing care: _____

Wavier Program: A&D _____ DD _____ Private Pay _____

Does the person needing care have a legal guardian? ☐ Yes ☐ No

If yes, name of legal guardian _____

Guardian's Phone Numbers: (home/work/cell) _____

Spouse's Legal Name: _____ Date of Birth: _____

Physical Address: _____

City: _____ Zip: _____

Mailing Address (If different than physical address): _____

City: _____ Zip: _____

Home Telephone Number: _____ Cellular Phone Number: _____

Work Number: _____ E-mail Address: _____

Emergency Contact: Name: _____ Telephone Number _____

Please provide detailed driving instructions to your home from the Regional CFH Office:

HOME INFORMATION

Please indicate which of the following apply:

- ☐ I am the owner of the home
- ☐ I pay rent to live in the home
- ☐ I live in the home with the person(s) who own/rent the home

Is this residence a HUD approved manufactured home? ☐ Yes ☐ No

If yes, please note the year it was manufactured. _____ (HUD approved would be after June 15, 1976).

Other Household Members (related or unrelated, excluding the resident): (Attach Additional Sheet if Needed)

Name	Relationship to provider	Birth Date

Will other household members be providing care or supervision to residents? ☐ Yes ☐ No

If yes, please list:

Name	Type of Care

* Please note that homes wishing to provide care to residents in need of wheelchair access must comply with current ADA Accessibility Guidelines (IDAPA 16.03.19.700.05)

PLANS FOR SUBSTITUTE CARE

Please describe how resident(s) in your home will be cared for when you are unable to be at home for either planned or emergency reasons.

Do you have a substitute caregiver identified? ☐ Yes ☐ No

If so, please list substitute caregiver's name.

_____

*Please note that all substitute caregivers must have completed a Department criminal history/background check, First Aid, CPR and the Assistance With Medication course.

EDUCATION

Do you have special training, education, license, certification, or experience delivering care to people? Please explain:

What languages do you speak? _____

Do you need an interpreter for English? ☐ Yes ☐ No

If yes, please make arrangements to have your interpreter attend classes and surveys.

If yes, please list the name and phone number of someone that we may contact if we need to get in touch with you.

NAME:	Phone Number(s)

HEALTH STATUS:

Do you or anyone else residing in your home have a disability, disease, or other mental and/or physical health condition which could impact your ability to provide care to another individual? ☐ Yes ☐ No

If yes, please describe:

EMPLOYMENT:

Are you employed outside the home? ☐ Yes ☐ No

If yes, please answer the following:

Employer: _____

Days and hours worked per week, i.e. Monday – 8am to 5pm:	

Have you ever been certified or licensed in Idaho, or any other state, as a Certified Family Home, Assisted Living Facility, Day Care, or Child Care provider? If yes, please list:

Please list any past denial of an application to be certified or licensed as a care home or facility. Also, describe any past disciplinary actions or revocations of certificates or licenses taken against you or family members in either Idaho or any other jurisdiction:

By signing this application, I assure the Department that I have thoroughly read and understand the Rules Governing Certified Family Homes, or that I will read and understand them, and I will comply with all of the provisions of these rules. I agree that my home, and all records pertaining to my home's operation and residents, will be accessible to the Department at all times for the purposes of inspection with, or without, prior notification. I further consent to the release of information to the department by any individual or agency that may have information affecting our eligibility for certification.

I hereby certify that the information provided in this application is true and correct to the best of my knowledge.

_____ _____

Signature of Applicant Date