



State of Idaho



The Idaho Department of Health & Welfare certifies that

Primary Care Giver's Name

has been granted *(full or provisional)* certification as a **Certified Family Home** at this address:

Physical Address of CFH

City, State, Zip of CFH

This home is certified to provide care to _____ Resident(s).

CFH _____

This provider/home meets all standards set forth in the Department of Health & Welfare
Rules and Regulations Governing Certified Family Homes.

This certification is effective from _____ until _____ unless suspended or revoked by the Department of Health & Welfare.

This certificate is not transferable.

Signature, Department of Health & Welfare

Date