APPLICATION TO EXCEED THE TWO RESIDENT LIMIT

CERTIFIED FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

Provider's Name:	Phone:	Date:

Address:

NUMBER OF PEOPLE LIVING IN THE HOME (Please do NOT include your resident(s) here.)

Number of Adults	Number of Children	Children's Ages

EMPLOYMENT STATUS OF EACH CAREGIVER

Other **gainful** employment?	NO	YES	If Yes - where, which days and what hours?
Caregiver #1 (Please list name below)			
Caregiver #2 (Please list name below)			

QUALIFICATIONS OF EACH CAREGIVER   Please include dates of certifications.

Caregiver #1	
Caregiver #2	

List any further caregivers on a separate sheet.

CURRENT / PROPOSED RESIDENTS AND CARE REQUIRED

Attach copies of the current assessment (e.g., Findings, SIS), plan of service, history & physical exam, and medication list.

Resident #1 Name:	Birth Date:	Sex:

Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:

Resident #2 Name:	Birth Date:	Sex:

Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay	Hours of direct care needed per day?
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:	Diagnoses / Behaviors / Special Needs:

Resident #3 Name:		Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay		Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:		Diagnoses / Behaviors / Special Needs:	

Resident #4 Name:		Birth Date:	Sex:
Payer: ❑ A&D Waiver ❑ DD Waiver ❑ Private Pay		Hours of direct care needed per day?	
Does the resident have a legal guardian? ❑ No - Please provide an emergency contact name & phone number for resident: ❑ Yes - Please provide the guardian's name and phone number:		Diagnoses / Behaviors / Special Needs:	

DESCRIPTION OF YOUR HOME
Please provide a sketch of your home's floor plan that identifies the bedrooms listed below.

Bedrooms for Resident Use	Room's Square Footage	Proposed Occupant(s)
Bedroom #1		
Bedroom #2		
Bedroom #3		
Bedroom #4		

My signature below certifies that I have read, understand, and will comply with the rules governing exceptions to the two-bed limit in my Certified Family Home.

_____

Signature of Provider   Date

** PLEASE NOTE **
An Exception Request to IDAPA 16.03.19.100.03 must accompany this form. If more than one resident requires nursing facility level of care, also include IDAPA 16.03.19.130.