CERTIFIED
FAMILY HOME PROGRAM

RENEWAL APPLICATION

Renewal Application is required annually for existing providers.

IDAHO DEPARTMENT OF HEALTH & WELFARE

SECTION 1: PROVIDER INFORMATION

The provider is the adult responsible for maintaining the certified family home and providing care to residents.

a. Full Legal Name:		b. Certificate No.:
c. Telephone Number: ( )	d. Email:	
e. Mailing Address *(if different than Section 2)*:		
f. Mailing City:	g. Mailing State:	h. Mailing ZIP:

i. Are you employed outside the home? Yes ☐ No ☐

If yes, please provide:
Employer Name: _____
Work Number: (_____)_____
Work Address: _____
_____

DAY	*HOURS*
Sunday	_____
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

SECTION 2: HOME INFORMATION

The home is the residential setting where the provider lives with the residents.

a. Physical Address:		
b. Physical City:	c. Physical State:	d. Physical ZIP:

SECTION 3: SERVICES

The provider is offering the following services in the home (check all that apply):

a. Care to residents with the following conditions/diagnoses:

- ☐ Alzheimer's or Other Dementia
- ☐ Developmental Disability
- ☐ Elderly
- ☐ Mental Illness
- ☐ Physical Disability
- ☐ Traumatic Brain Injury

b. Accommodations for the following:

- ☐ Non-relative Residents
- ☐ Emergency Placements
- ☐ Alternate Care
- ☐ Hourly Adult Care
- ☐ Residents with Pets
- ☐ Residents who Smoke
- ☐ Other – *Please describe:* _____
- ☐ Female Residents Only
- ☐ Male Residents Only
- ☐ Residents who are Deaf
- ☐ Residents who are Blind
- ☐ Non-ambulatory Residents
- ☐ Non-English-speaking Residents Language: _____

SECTION 4: SUBSTITUTE CARE

Substitute caregivers are adults who provide care to residents in the provider's absence. Incidental supervision may be provided by other adults without substitute caregiver qualifications, but incidental supervision is limited to four (4) hours per week and does not include care to residents. ***List any substitute caregivers below.***

1a. Full Legal Name:	1b. Date of Birth:
2a. Full Legal Name:	2b. Date of Birth:
3a. Full Legal Name:	3b. Date of Birth:
4a. Full Legal Name:	4b. Date of Birth:

Continue on a separate sheet if there are additional substitute caregivers.

SECTION 5: OTHER MEMBERS OF THE HOUSEHOLD

Outside of the provider, list all other members of the household who currently live in the home or have moved in or out of the home during the previous year. *Please include children living in the home in this section. Move-in and move-out dates may be left blank if not applicable within the last year. The term "resident" as used in this section refers to a vulnerable adult living in the home and receiving care from the provider.*

1a. Full Legal Name:		1b. Date of Birth:
1c. Gender: Male ☐ or Female ☐	1d. Relationship to Provider:	
1e. Move-in Date:	1f. Move-out Date:	1g. CFH Resident? Yes ☐ No ☐

2a. Full Legal Name:		2b. Date of Birth:
2c. Gender: Male ☐ or Female ☐	2d. Relationship to Provider:	
2e. Move-in Date:	2f. Move-out Date:	2g. CFH Resident? Yes ☐ No ☐

3a. Full Legal Name:		3b. Date of Birth:
3c. Gender: Male ☐ or Female ☐	3d. Relationship to Provider:	
3e. Move-in Date:	3f. Move-out Date:	3g. CFH Resident? Yes ☐ No ☐

4a. Full Legal Name:		4b. Date of Birth:
4c. Gender: Male ☐ or Female ☐	4d. Relationship to Provider:	
4e. Move-in Date:	4f. Move-out Date:	4g. CFH Resident? Yes ☐ No ☐

5a. Full Legal Name:		5b. Date of Birth:
5c. Gender: Male ☐ or Female ☐	5d. Relationship to Provider:	
5e. Move-in Date:	5f. Move-out Date:	5g. CFH Resident? Yes ☐ No ☐

6a. Full Legal Name:		6b. Date of Birth:
6c. Gender: Male ☐ or Female ☐	6d. Relationship to Provider:	
6e. Move-in Date:	6f. Move-out Date:	6g. CFH Resident? Yes ☐ No ☐

7a. Full Legal Name:		7b. Date of Birth:
7c. Gender: Male ☐ or Female ☐	7d. Relationship to Provider:	
7e. Move-in Date:	7f. Move-out Date:	7g. CFH Resident? Yes ☐ No ☐

Continue on a separate sheet if there are additional members of the household.

SECTION 6: APPLICATION VERIFICATION

a. My signature below means that I hereby request recertification as a certified family home.	
b. My signature below means that I hereby confirm that all substitute caregivers, other adults currently living in my home other than the resident(s), and I have not been convicted of a misdemeanor or felony since last clearing a Department criminal history and background check.	
c. My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.	
d. Provider Signature:	e. Date: