CERTIFIED
FAMILY HOME PROGRAM

REQUEST FOR NEW ADMISSION

The Request for New Admission is submitted for Department approval of a prospective resident.

IDAHO DEPARTMENT OF HEALTH & WELFARE

PROVIDER INFORMATION

The provider is the adult responsible for maintaining the home and providing care to the resident(s).

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email Address:	
What specific training and/or experience does the provider have that ensures adequate care at the levels or types of services required to meet the prospective resident's needs can be provided?		

HOME INFORMATION

The home is the residential setting where the provider lives with the resident(s).

Physical Address:		
Physical City:	Physical State:	Physical ZIP:
Is the home equipped with adaptive equipment (e.g., ramps, grab bars, etc.)? Yes ☐ No ☐ *If yes, please list:*		Current # in Household: Number of Bedrooms: Number of Bathrooms:
Has the provider **attached** a copy of the home's floor plan indicating each resident's sleeping room (including the room's square footage) and potential egress/ingress barriers? Yes ☐ No ☐		

STAFFING INFORMATION

The provider is the adult primarily responsible for maintaining the home and providing care to the resident(s). Qualified substitute caregivers (i.e., current CPR/First Aid certification, medication course, and cleared Department criminal history and background check) may provide care to residents when the provider is unavailable for up to 30 consecutive days. Regular staff may not have unsupervised contact with residents without a criminal history check.

Is the provider 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	_____

SUBSTITUTE CAREGIVER OR REGULAR STAFF NAME	SCHEDULE

PROSPECTIVE RESIDENT INFORMATION

The prospective resident is the vulnerable adult for whom the provider is requesting approval to admit to the home. Unless admitted on an emergency basis per IDAPA 16.03.19.260.03.a., the prospective resident must not move into the provider's home until this request is approved by the Department.

Full Legal Name:	Date of Birth:
Gender: Male ☐ or Female ☐	Relationship to Provider:
Diagnoses/Behaviors:	
Payment Program: ☐ Aged & Disabled Waiver, Medicare/Medicaid Coordinated Program, or Idaho Medicaid Plus ☐ Developmental Disabilities Waiver, or Self Direction ☐ Private Pay	
Does the resident have a legal guardian or a durable power of attorney (POA) for health care? Yes ☐ No ☐ *If yes, Representative Name: _____ Telephone Number: (_____)_____*	
Does the resident have any physical or sensory impairments (e.g., non-ambulatory, blind, etc.)? Yes ☐ No ☐ *If yes, please describe:*	
Has the provider **reviewed and attached** a copy of the resident's recent history and physical exam from the resident's health care professional reflecting the resident's current health status? Yes ☐ No ☐	
Has the provider **reviewed and attached** a copy of the resident's current medications and treatments, and ensured lawful assistance with such can be offered by the home? Yes ☐ No ☐	
If applicable, has the provider **reviewed and attached** a copy of the resident's plan of service from another health care setting, if one exists, in effect within the previous six (6) months? Yes ☐ No ☐	

EXISTING RESIDENT INFORMATION

Leave blank if not applicable. An existing resident is a vulnerable adult already receiving services in the provider's home. If both the prospective admit and an existing resident are nursing facility level of care, the provider must also submit an Exception Request to IDAPA 16.03.19.130 with this request.

Full Legal Name:	Date of Birth:
Gender: Male ☐ or Female ☐	Relationship to Provider:
Diagnoses/Behaviors:	
Payment Program: ☐ Aged & Disabled Waiver, Medicare/Medicaid Coordinated Program, or Idaho Medicaid Plus ☐ Developmental Disabilities Waiver, or Self Direction ☐ Private Pay	
Required Number of Daily Hands-on Care Hours per the Assessment or Program:	

ADMISSION REQUEST AND DECISION

Anticipated Date of Admission:	Admitted on an Emergency Basis? Yes ☐ No ☐
My signature below means I certify information provided in this request is true and correct to the best of my knowledge.	
Provider Signature:	Date:
To Be Completed by the Department	
Is placement of the requested new admission approved?* Yes ☐ No ☐	
Certifying Agent Signature:	Date:

**The certifying agent must notify the provider of the Department's decision within five (5) business days of receipt of this request. When verbal notification is given, return this completed form to the provider within ten (10) business days. If approved and the new admit is receiving public assistance, also provide a copy of this form to Regional Medicaid Services.*