



APPLICATION | PART A

Part A is submitted to initiate the application process or a current provider's move to a new home.



SECTION 1: APPLICANT INFORMATION

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

a. Full Legal Name:		b. Date of Birth:	
c. Other Names Used (<i>maiden, married, etc.</i>):			
d. Telephone Number: ()		e. Email Address:	
f. Mailing Address:			
g. Mailing City:		h. Mailing State:	i. Mailing ZIP:
j. Are you an existing certified family home provider moving to a new residence and requesting temporary certification?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If yes, please include with this application:</i> <ul style="list-style-type: none"> • A copy of a recent (within one year) electrical inspection report for the new residence, and • If the home is equipped with fuel-fired heating devices (e.g., wood stove, gas furnace, etc.), recent (within one year) inspection reports for such devices. 			
k. Do you or anyone else living in your home have a disease, disability, or other mental and/or physical health condition that could impact your ability to safely provide care to the resident(s)?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:			
l. Do you currently hold a foster care license?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
m. Are you currently being investigated, in any jurisdiction, for a crime or concerns related to a health care, child care, or foster care certificate or license?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If yes, please describe including the entity conducting the investigation:</i> _____ _____ _____ _____			
n. Have you had a health care, child care, or foster care certificate or license denied or revoked in the past, or other disciplinary action taken or in the process of being taken in any jurisdiction?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>If yes, please describe including the name and type of agency/facility, and the date and type of action:</i> _____ _____ _____ _____			
o. Have you ever been convicted of fraud, gross negligence, abuse, assault, battery, or exploitation?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you been convicted of any other criminal offense within the past five (5) years?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
p. Have you been ordered by a court not to operate a health facility, residential care or assisted living facility, or certified family home?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
q. Are you listed on the Child Abuse, Adult Protection, or Sexual Offender Registries?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
r. Are you listed on the Medicaid Exclusion List?		Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 2: HOME INFORMATION

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

a. Physical Address:		b. Physical ZIP:	
c. Physical City:		d. Physical State:	e. Number in Household:
f. Ownership: The applicant or applicant's spouse <u>owns</u> the home. <input type="checkbox"/> or The applicant or applicant's spouse <u>rents</u> the home. <input type="checkbox"/>		g. Number of Bedrooms:	
		h. Number of Bathrooms:	
i. Type: Stick Built <input type="checkbox"/> or Manufactured/Modular <input type="checkbox"/> Year Built:	j. Is the home located within a lawfully constituted fire district? Yes <input type="checkbox"/> No <input type="checkbox"/>		
k. Is the home served by an all-weather road open to motor vehicles year-round?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
l. Is the home equipped with any adaptive equipment (e.g., ramps, grab bars, etc.)? <i>If yes, please list:</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 3: RESIDENT INFORMATION

A resident is an adult needing care. If there is no prospective resident, leave this section blank. If there is a second prospective resident, repeat this section on a separate sheet of paper and submit it with Application Part A.

a. Full Legal Name:		b. Date of Birth:	
c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		d. Relationship to Applicant:	
e. Diagnoses/Behaviors: _____			
f. Payer Source (<i>select only one; share of cost is Public Assistance</i>):		Public Assistance <input type="checkbox"/>	Private Pay <input type="checkbox"/>
g. Does the resident have a legally appointed guardian or a power of attorney (POA)? If yes, Guardian/POA Name: _____ Telephone Number: (____) _____		Yes <input type="checkbox"/> No <input type="checkbox"/>	
h. Is the resident's name listed on the lease/deed/mortgage of the applicant's home?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
i. Does the resident have any physical or sensory impairments (e.g., non-ambulatory, blind, etc.)? <i>If yes, please describe:</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>	

SECTION 4: OTHER MEMBERS OF THE HOUSEHOLD *List all other members of the household below, except the applicant.*

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:
5a. Full Legal Name:	5b. Date of Birth:
6a. Full Legal Name:	6b. Date of Birth:
7a. Full Legal Name:	7b. Date of Birth:

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

SECTION 5: APPLICATION VERIFICATIONS

a. My signature below means that by submitting this application, I understand that I will be invoiced for the \$150.00 non-refundable application fee, unless I am an existing certified family home provider moving to a new residence. I also understand that payment of the application fee is required before attending New Provider Orientation.	
b. My signature below means that I hereby assure the Department that I have thoroughly read and reviewed Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes," or that I will read and review these rules, and I am prepared to comply with all provisions in this chapter.	
c. My signature below means that I hereby confirm that I am not under the control or influence of any person who is described in Subsections 113.01-07 of IDAPA 16.03.19 (i.e., a person who would answer "yes" to any of the questions in Subsections 1.m-r on this application).	
d. My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.	
e. Applicant Signature:	f. Date:
g. Certifying Agent Signature*:	h. Date**:

* The certifying agent will sign and date Application Part A when it is determined to be complete and the applicant's information is data-entered into the program database.

** The Department reserves the right to terminate the application if the applicant has not attended New Provider Orientation within six (6) months of this date on Application Part A.