



# APPLICATION | PART B

Part B is submitted to complete the application process.



## SECTION 1: APPLICANT INFORMATION

The applicant is the adult responsible for maintaining the home and providing care to residents.

a. Full Legal Name: _____		b. Date of Birth: _____	
c. Date Attended New Provider Orientation: _____		d. Date Completed Medications Course: _____	
e. Expiration of First Aid Certificate: _____		f. Expiration of Adult CPR Certificate: _____	
g. List any special training, education, licensure, certification, or experience related to caregiving, if any: _____ _____			
h. Date Cleared Department of Health & Welfare Criminal History and Background Check: _____			
i. What languages do you speak?			
<input type="checkbox"/> English	<input type="checkbox"/> Italian	<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Spanish	<input type="checkbox"/> Serbo-Croatian	<input type="checkbox"/> Nepali	
<input type="checkbox"/> French	<input type="checkbox"/> Russian	<input type="checkbox"/> Tagalog	
<input type="checkbox"/> German	<input type="checkbox"/> Cantonese or Mandarin	<input type="checkbox"/> American Sign Language	
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Native North American	
<input type="checkbox"/> Romanian	<input type="checkbox"/> Other – please list: _____		
j. Do you need an English interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please provide: Name of Interpreter: _____ Phone Number: (____) _____	
k. Do you intend to be employed outside the home? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please provide:	
Employer Name: _____		<u>DAY</u>	<u>HOURS</u>
Work Number: (____) _____		Sunday	_____
Work Address: _____		Monday	_____
_____		Tuesday	_____
_____		Wednesday	_____
_____		Thursday	_____
_____		Friday	_____
_____		Saturday	_____

**SECTION 2: SUBSTITUTE CARE** Substitute caregivers are adults who provide care to residents in the applicant'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: _____	
1c. Expiration of First Aid: _____		1d. Expiration of Adult CPR: _____	
1e. Date Completed Medications Course: _____		1f. Date Fingerprinted for DHW Check: _____	
2a. Full Legal Name: _____		2b. Date of Birth: _____	
2c. Expiration of First Aid: _____		2d. Expiration of Adult CPR: _____	
2e. Date Completed Medications Course: _____		2f. Date Fingerprinted for DHW Check: _____	

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

**SECTION 3: SERVICES**

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

<p>a. Care to residents with the following conditions/diagnoses:</p> <p><input type="checkbox"/> Alzheimer's or Other Dementia</p> <p><input type="checkbox"/> Developmental Disability</p> <p><input type="checkbox"/> Elderly</p> <p><input type="checkbox"/> Mental Illness</p> <p><input type="checkbox"/> Physical Disability</p> <p><input type="checkbox"/> Traumatic Brain Injury</p>	<p>b. Accommodations for the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Non-relative Residents</td> <td style="width: 50%;"><input type="checkbox"/> Female Residents Only</td> </tr> <tr> <td><input type="checkbox"/> Emergency Placements</td> <td><input type="checkbox"/> Male Residents Only</td> </tr> <tr> <td><input type="checkbox"/> Alternate Care</td> <td><input type="checkbox"/> Residents who are Deaf</td> </tr> <tr> <td><input type="checkbox"/> Hourly Adult Care</td> <td><input type="checkbox"/> Residents who are Blind</td> </tr> <tr> <td><input type="checkbox"/> Residents with Pets</td> <td><input type="checkbox"/> Non-ambulatory Residents</td> </tr> <tr> <td><input type="checkbox"/> Residents who Smoke</td> <td><input type="checkbox"/> Non-English-speaking Residents</td> </tr> <tr> <td><input type="checkbox"/> Other – Please describe: _____</td> <td>Language: _____</td> </tr> </table>	<input type="checkbox"/> Non-relative Residents	<input type="checkbox"/> Female Residents Only	<input type="checkbox"/> Emergency Placements	<input type="checkbox"/> Male Residents Only	<input type="checkbox"/> Alternate Care	<input type="checkbox"/> Residents who are Deaf	<input type="checkbox"/> Hourly Adult Care	<input type="checkbox"/> Residents who are Blind	<input type="checkbox"/> Residents with Pets	<input type="checkbox"/> Non-ambulatory Residents	<input type="checkbox"/> Residents who Smoke	<input type="checkbox"/> Non-English-speaking Residents	<input type="checkbox"/> Other – Please describe: _____	Language: _____
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<input type="checkbox"/> Residents with Pets	<input type="checkbox"/> Non-ambulatory Residents														
<input type="checkbox"/> Residents who Smoke	<input type="checkbox"/> Non-English-speaking Residents														
<input type="checkbox"/> Other – Please describe: _____	Language: _____														

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

**applicant.** Any other adult members of the household, except for the resident(s)—that is, the adults needing care—must complete a self-declaration form, must be fingerprinted, and must not have any designated crimes listed in IDAPA 16.05.06 “Criminal History and Background Checks.”

1a. Full Legal Name:		1b. Date of Birth:	
1c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		1d. Relationship to Applicant:	
1e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
2a. Full Legal Name:		2b. Date of Birth:	
2c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		2d. Relationship to Applicant:	
2e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
3a. Full Legal Name:		3b. Date of Birth:	
3c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		3d. Relationship to Applicant:	
3e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
4a. Full Legal Name:		4b. Date of Birth:	
4c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		4d. Relationship to Applicant:	
4e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
5a. Full Legal Name:		5b. Date of Birth:	
5c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		5d. Relationship to Applicant:	
5e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
6a. Full Legal Name:		6b. Date of Birth:	
6c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		6d. Relationship to Applicant:	
6e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			
7a. Full Legal Name:		7b. Date of Birth:	
7c. Gender: Male <input type="checkbox"/> or Female <input type="checkbox"/>		7d. Relationship to Applicant:	
7e. Date Fingerprinted for DHW Criminal History and Background Check (if not a resident or minor):			

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

**SECTION 5: HOME OWNERSHIP** *This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?*

a. The lease, deed, or mortgage listing the name of the applicant or applicant's spouse:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. The current homeowner's or renter's insurance policy:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 6: UTILITIES** *This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?*

a. City water bill, or, if using a non-municipal water source (e.g., private well) in the home, a current statement from the local environmental health agency that the water supply meets legal standards or, if the local environmental health agency cannot provide this information, a statement to that affect in writing from the local environmental health agency:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. City sewer bill, or, if using a non-municipal sewage disposal system (e.g., septic tank), a current statement from the local environmental health agency that the sewage system meets legal standards, or if the local environmental health agency cannot provide this information, a statement to that affect in writing from the local environmental health agency:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Dependable phone service:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 7: NON-MUNICIPAL WATER OR SEWER** *This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. Leave subsections blank that do not apply. Does the applicant have available evidence of the following?*

a. If using a non-municipal water source (e.g., private well) in the home, a recent (within one year) report from an accredited laboratory showing an absence of bacterial contamination:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. If using a septic tank, proof that the tank has been pumped recently (within one year) or a statement from a company permitted to clean septic tanks that pumping was not necessary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 8: EMERGENCY PREPAREDNESS** *This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. The applicant must answer "Yes" to each question in this section in order for the application to be considered complete. Does the applicant have available evidence of the following?*

a. Proof that the home is in a lawfully constituted fire district (e.g., letter from the fire district):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. A home fire evacuation plan drawing with at least 2 routes of escape from each room, an outside meeting area after evacuation, and the person responsible for relaying information to firefighters:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. A written emergency plan addressing confinement in the home (e.g., shelter-in-place orders) for at least 72 hours and considering, at minimum, adequate food, water, and medications:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. A written emergency plan addressing evacuation orders from the home (e.g., due to wildfire) including pre-arranged plans to shelter within the local community and in a town outside the local community, and considering necessary supplies to be kept in a state of preparedness:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e. A written procedure for any situation in which the applicant becomes incapacitated:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f. Power to a phone in the event of an extended electrical outage (most landlines will still function during an outage; VOIP and cell phones will need back-up power of some kind, such as an uninterruptible power supply, generator, or portable power bank):	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 9: FIRE/LIFE SAFETY** *This section pertains to the home specified in Application Part A, Section 2, which should have previously been submitted to the certifying agent. Leave subsections blank that do not apply. Does the applicant have available evidence of the following?*

a. Functioning smoke alarms installed in each sleeping room, each hallway, and on each level:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Functioning carbon monoxide alarms on each level of the home if the home is equipped with gas or other fuel-burning appliances or devices, or has an enclosed, attached garage:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
c. Recent (within one year) inspections of all fuel-fired heating devices (e.g., wood or pellet stoves, gas furnaces or fireplaces, etc.) by persons in the business of servicing such systems, indicating that the system is in good working order (if heating in the home is provided entirely by an all-electric system, please have the electrical inspector indicate so on the electrical inspection):	Yes <input type="checkbox"/>	No <input type="checkbox"/>
d. A recent (within one year) electrical inspection conducted by a licensed electrician or the local/state electrical inspector indicating that all wiring in the home complies with local code:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
e. Receipts from recent (within one year) purchases of 5 lb. dry chemical multipurpose 2A:10B:C portable fire extinguishers, one for each level of the home, or a recent service inspection of such:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
f. Firearms, if present in the home, are kept locked:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SECTION 10: APPLICATION VERIFICATIONS**

a. My signature below means that I have thoroughly read Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Rules Governing Certified Family Homes," and I am prepared to comply with all provisions in this chapter.	
b. My signature below means that I hereby agree that my home, residents living in my home, and all records pertaining to the residents and my home's operation will be accessible to the Department at all times for the purposes of inspection, with or without prior notice.	
c. My signature below means that I hereby consent to the release of information affecting my eligibility for certification as a certified family home provider to the Department by any individual or agency.	
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: