



RENEWAL APPLICATION

Renewal Application is required annually for existing providers.



SECTION 1: PROVIDER AND HOME INFORMATION

The provider is the adult responsible for maintaining the certified family home and providing care to residents. The home is the residential setting where the provider lives with the residents.

a. Full Legal Name:		b. Certificate No.:	
c. Telephone Number: ()		d. Email:	
e. Mailing Address:			
f. Mailing City:		g. Mailing State:	h. Mailing ZIP:
i. Home Address (if different than mailing address):			
j. Home City:		k. Home State:	l. Home ZIP:
m. Are you employed outside the home?		Yes	No
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: OPTIONAL 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 3: 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 4: CURRENT MEMBERS OF THE HOUSEHOLD *List everyone living in the home. The term "resident" refers to a vulnerable adult living in the home and receiving care from the provider.*

1a. Full Legal Name:		1b. Date of Birth:	
1c. Male or Female	1d. Relationship to Provider:		1e. CFH Resident? Yes No
2a. Full Legal Name:		2b. Date of Birth:	
2c. Male or Female	2d. Relationship to Provider:		2e. CFH Resident? Yes No
3a. Full Legal Name:		3b. Date of Birth:	
3c. Male or Female	3d. Relationship to Provider:		3e. CFH Resident? Yes No
4a. Full Legal Name:		4b. Date of Birth:	
4c. Male or Female	4d. Relationship to Provider:		4e. CFH Resident? Yes No
5a. Full Legal Name:		5b. Date of Birth:	
5c. Male or Female	5d. Relationship to Provider:		5e. CFH Resident? Yes No
6a. Full Legal Name:		6b. Date of Birth:	
6c. Male or Female	6d. Relationship to Provider:		6e. CFH Resident? Yes No

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

SECTION 5: HOUSEHOLD CHANGES *List everyone who has moved in or out of the home in the last year.*

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	

Continue on a separate sheet if additional members of the household have moved in/out in the last year.

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: