CERTIFIED
FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAPA 16.03.19.101

APPLICATION PART A

Email to CFHCC@DHW.IDAHO.GOV or Fax to 208-239-6250

1. Applicant Information (i.e., the person applying to be the CFH provider)

Full Legal Name (per legal ID):		
Preferred Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.		Date of Birth:
Telephone Number:	Email:	
Home Address:		
Home City:	Home State:	Home Zip:
Mailing Address (*if different than home address*):		
Mailing City:	Mailing State:	Mailing Zip:

2. Screening Questions ("Yes" answers require consultation with a certifying agent)

Excluding the "residents" (i.e., vulnerable adults to whom you will provide care), do you or anyone else living in your home have a disease, disability, or other mental and/or physical health condition that could impact <u>your</u> ability to safely provide care to the residents? If yes, please describe:	☐ Yes ☐ No
Do any of the following apply to you or anyone in your household?	
Currently hold a child foster care license.	☐ Yes ☐ No
Under investigation, in any jurisdiction, for criminal activity or for concerns related to a healthcare, childcare, or foster care certificate or license. If yes, provide details:	☐ Yes ☐ No
Had a healthcare, childcare, 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. If yes, provide details:	☐ Yes ☐ No
Conviction for any crime against a child or a vulnerable adult or involving abuse, arson, assault, battery, death, exploitation, or neglect.	☐ Yes ☐ No
Conviction for any other criminal offense within the past five (5) years.	☐ Yes ☐ No
Ordered by a court not to operate a health facility, residential assisted living facility, or certified family home.	☐ Yes ☐ No
Listed on the Child Protection, Adult Protection, or Sexual Offender registries.	☐ Yes ☐ No
Listed on the Medicaid Exclusion List.	☐ Yes ☐ No

3. Languages

Please list any languages other than English that you speak:
Do you need an English interpreter? ☐ Yes ☐ No

4. Home Information

Is your home any of the following? ☐ A recreational vehicle (e.g., fifth-wheel trailer, truck camper, or commercial coach). ☐ A manufactured or modular tiny house with 400 square feet or less of floor space, excluding the lofts. ☐ A tent-like structure (e.g., a yurt). ☐ A manufactured or modular home <u>not approved</u> by the Department of Building Safety or Housing and Urban Development, or with unregulated or unapproved modifications/additions.		
Ownership: ☐ The applicant or the applicant's spouse **<u>owns</u>** the home ☐ The applicant or the applicant's spouse **<u>rents</u>** the home		
Number in Household:	Number of Bedrooms:	Number of Bathrooms:
Is the home accessible to emergency services and other services year-round? ☐ Yes ☐ No		
Is the home equipped with any adaptive equipment? (ramps, grab bars, etc.) ☐ Yes ☐ No *If yes, please list:*		

5. Resident Information (i.e., the vulnerable adult who will receive care)

Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Diagnoses/Behaviors:	
Estimated Hours of Daily Direct Care (i.e., 1:1 services—excludes passive supervision):	
Payment Program: ☐ Medicaid/Public Funds ☐ Private Pay	
Does the resident have a legal Guardian or Power of Attorney (POA) for healthcare? ☐ Yes ☐ No If Yes, Representative Name: _____ Phone:_____	
Is the resident's name listed on the lease/deed/mortgage of the applicant's home? ☐ Yes ☐ No	
Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No *If yes, please describe:*	

Duplicate this section for any additional residents.

6. Other Household Members

(besides yourself and the resident[s], list everyone else—including minors—living in your home)

Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:
Full Legal Name:	Date of Birth:
Gender: ☐ Male ☐ Female	Relationship to Applicant:

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

7. Application Verification

My signature below means that by submitting this application, I understand that I will be invoiced for the $150.00 non-refundable application fee through the Department of Health and Welfare's Central Revenue Unit. I understand that payment of the application fee is required before attending New Provider Orientation. I also understand that if I do not pay the application fee within six (6) months, my application may be administratively terminated by the department.
My signature below means that I hereby consent to the release of information affecting my eligibility for certified family home certification to the department by any individual or agency.
My signature below means that I hereby confirm that I am not under the control or influence of any other person (e.g., spouse, partner, close relative, etc.) who has had a department criminal history and background check result in an Unconditional Denial, has had a health facility or child care license or certificate denied or revoked, operated a health facility without a certificate or license, or has been ordered by a court not to operate a health facility.
My signature below means that I hereby certify the information provided in this application is true and correct to the best of my knowledge.

Applicant Signature: _____ Date: _____

Certifying Agent Signature: _____ Date: _____