CERTIFIED
FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAPA 16.03.19.101

APPLICATION PART B

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

Submit this application to the department only after you have attended New Provider Orientation and completed EVERYTHING in this application.

1. Applicant Information

Full Legal Name:
List any special training, education, licensure, or experience, if any, related to caregiving:
If the applicant works outside the home, is the applicant immediately available to consult with staff when needed? ☐ Yes ☐ No Employer Name: _____Work Phone: _____
Applicant's Emergency Contact: _____ Phone: _____

2. Services Offered (check all that apply)

Offering care to residents with the following conditions/diagnoses: ☐ Alzheimer's or Other Dementia ☐ Developmental Disability ☐ Elderly ☐ Mental Illness ☐ Physical Disability ☐ Traumatic Brain Injury	☐ Non-relative Residents Optional accommodations for the following if you are interested in serving non-related residents: ☐ Emergency Placements ☐ Alternate Care ☐ Hourly Adult Care (Day Care) ☐ Residents with Pets ☐ Residents who Smoke ☐ Female Residents Only ☐ Male Residents Only ☐ Residents who are Deaf ☐ Residents who are Blind ☐ Non-ambulatory Residents ☐ Non-English-speaking Residents Language:_____

3. Substitute Caregivers (if applicable)

Substitute Caregiver Name	Age	Expiration Date of CPR	Expiration Date of First Aid	Date of Background Clearance	Date of Medication Course

4. Certified Bed Capacity (maximum of four)

Residents are assigned to certified beds. The bed may be in a single-occupancy sleeping room of at least 100 square feet, or in a double-occupancy sleeping room of at least 160 square feet.	Requested Number of Certified Beds: _____

*For all sections below, **maintain documentation** or observable conditions showing that your home meets the statement. This application is your **CHECKLIST** for certification.*

5. Applicant Qualifications

☐ A certificate or transcript showing that the applicant has completed a department-approved medications course through an Idaho technical college or a license showing that the applicant is a licensed practical nurse, registered nurse, physician's assistant, or medical doctor.
☐ Current certification in adult CPR and first aid that includes hands-on skills training.

6. DHW Criminal History and Background Check Clearances

List all adults, including the applicant, living in the home except for the "residents" (i.e., vulnerable adults to whom the applicant will provide services); each clearance must be affiliated with the CFH program by using Pay Code Z6NGS.

Full Legal Name:	Date of Clearance:
Full Legal Name:	Date of Clearance:
Full Legal Name:	Date of Clearance:
Full Legal Name:	Date of Clearance:
Full Legal Name:	Date of Clearance:

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

7. Life Safety

The home's water supply is safe as demonstrated by either: ☐ A city water bill. OR ☐ Proof that the private well water was tested by an accredited laboratory within the last 12 months and showed an absence of bacterial contamination (E. coli and coliform bacteria).
The home's sewage disposal system is maintained in good working condition as demonstrated by either: ☐ A city sewer bill. OR ☐ Proof that the private septic tank was pumped or other disposal system was serviced within the last 5 years.

☐ A written statement from a licensed plumber within the last 12 months indicating that the water and sewage systems in the home are in good working order.
☐ A written statement from a licensed HVAC professional within the last 12 months indicating that the heating and cooling systems in the home are in good operating condition.
☐ A written statement from a licensed electrician or the local/state electrical inspector within the last 12 months indicating that all electrical installations in the home are compliant with applicable local code and in good working order.
The household is protected from carbon monoxide poisoning as demonstrated by either: ☐ Functioning carbon monoxide alarms are installed on each level of the home. OR ☐ The home, its heating systems, and all household appliances are powered entirely by electricity requiring no gas or other fuels as evidenced by a written statement from a licensed electrician, AND the garage is either detached or not enclosed.
☐ Functional and dependable phone service is maintained. If cell phones are used, a backup power source is available to keep cell phones charged in the event of an extended power outage.
☐ Firearms, if present in the home, are secured (gun safe, trigger lock, etc.).
☐ A written Emergency Preparedness Plan containing the elements discussed in New Provider Orientation. A template was sent as part of the New Provider Orientation packet.

8. Fire Safety

☐ Proof that the home is in a lawfully constituted fire district OR the applicant holds an agreement with the nearest fire district that they will respond to the home if available. This can be a fire district letter, a line-item on a property tax bill, a written agreement with the nearest fire district, etc.
☐ Functioning smoke alarms are installed in each sleeping room, hallway, and on each level of home.
The risk of a chimney fire has been mitigated by either: ☐ Proof that a professional has cleaned the chimney for each wood-burning fireplace or pellet stove in the home within last 12 months OR ☐ The home is not equipped with wood-burning fireplaces or pellet stoves.
☐ Proof of an A:B:C-type fire extinguisher of at least 2.5 pound chemical fill weight that has been purchased or serviced within the last 12 months for each level of the home.

9. Home Occupancy and Insurance

☐ The lease, deed, or mortgage that lists the name of the applicant or applicant's spouse, or other proof that the applicant has a legal right to occupy the home and control the premises.
☐ Current homeowner's or renter's insurance policy.

10. Resident Admission (if applicable at the time of initial certification)

☐ The results of the resident's history and physical examination (i.e., after-visit summary) by a healthcare professional reflecting the resident's current health status conducted within the previous 12 months.
☐ If the resident is private-pay, a statement by a healthcare professional indicating that the resident is appropriate for certified family home care.
☐ If the resident lived in another healthcare setting (e.g., a skilled nursing facility, a residential assisted living facility, etc.) within the previous six (6) months, the prospective resident's plan of service in that setting.

11. Application Verification and Agreements

My signature below means that I hereby assure the Department of Health and Welfare that I have thoroughly read and reviewed Idaho Code, Title 39, Chapter 35, "Idaho Certified Family Homes," and Idaho Administrative Procedures Act (IDAPA) 16, Title 03, Chapter 19, "Certified Family Homes," and I am prepared to comply with all provisions in these chapters.	
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 certified family home's operation will be accessible to department staff at all times for the purposes of inspection, with or without prior notice.	
My signature below means that I understand I have 12 months from the date I attend New Provider Orientation to complete the application process. I also agree that failure to do so will mean that my application may be administratively terminated by the department.	
My signature below means that upon being issued a certified family home (CFH) certificate, I understand that I will be invoiced on a quarterly basis for the $25.00 monthly certification fee, which I agree to pay to the department through its Central Revenue Unit within at least 30 days of the date of the quarterly invoice.	
My signature below means that by submitting this application, I grant permission to the department to share my name and contact information with the public on its website for any CFH bed vacancies in my home. If I do not wish for my name and contact information to be made public on the department's website, I agree to decrease my certified bed capacity such that there are no vacancies by communicating the reduction in writing to my regional certifying agent.	
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: