CERTIFIED FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAPA 16.03.19.110.02

Relocation Application Part A

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

Expected Move Date: _____ (submit this completed application before move-in)

Section 1: Provider Information

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email:	
New Home Address:		
Home City:	Home State:	Home ZIP:
Mailing Address (*if different than new home address*):		
Mailing City:	Mailing State:	Mailing ZIP:

Section 2: New 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 loft.
☐ A tent-like structure (e.g., a yurt).
☐ A manufactured or modular home not approved by the Department of Building Safety (DBS) or Housing and Urban Development (HUD) with unregulated or unapproved modifications/additions.

Ownership: ☐ The applicant or the applicant's spouse **owns** the home.
☐ The applicant or the applicant's spouse **rents** 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:

Section 3: Inspection Reports to be Submitted with this Application

☐ Plumbing inspection from a licensed plumber within the last 12 months.
☐ Electrical inspection conducted by a licensed electrician within the last 12 months.
☐ Inspection of heating cooling systems by a licensed HVAC professional within the last 12 months.
☐ If applicable, professional cleaning for wood-burning fireplaces/pellet stoves within the last 12 months.

If a newly built home within the last 12 months, the Certificate of Occupancy meets the above requirements.

Section 4: Application Verification

I hereby certify the information provided herein is true and correct to the best of my knowledge.

Provider Signature: _____ Date: _____