CERTIFIED
FAMILY HOME PROGRAM

IDAHO DEPARTMENT OF HEALTH & WELFARE

IDAPA 16.03.19.111

Renewal Application

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

**Please submit this form at least 30 days prior to your certificate expiration.*

Section 1: Provider and Home Information

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email:	
Home Address:		
Home City:	Home State:	Home ZIP:
Mailing Address (*if different than mailing address*):		
Mailing City:	Mailing State:	Mailing ZIP:
Emergency Contact (name and phone number):		( )

Section 2: Services Offered (check all that apply)

☐ No changes to optional services since last year (*skip to section 3*)

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 (i.e., Adult 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:_____

Section 3: Certified Bed Capacity

How many CFH Residents does the provider wish to admit or retain, up to four (4):

Section 4: Substitute Care (*all boxes must be complete to qualify as a substitute caregiver*)

Substitute Caregiver Full Legal Name	Adult	Current CPR/FirstAid	Background Check	Medication Course
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

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

Section 5: Other Household Members
(list all persons—including yourself, residents, and minors—living in your home)

Full Legal Name:	Date of Birth:
Relationship to Provider: ☐ CFH Resident	Birth Sex: ☐ Male ☐ Female

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Full Legal Name:	Date of Birth:
Relationship to Provider: ☐ CFH Resident	Birth Sex: ☐ Male ☐ Female

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

Section 6: Household Changes (*list everyone who moved in or out in the last year*)

Full Legal Name:	Date of Birth:
Relationship to Provider: ☐ CFH Resident	Birth Sex: ☐ Male ☐ Female
Move In Date:	Move Out Date (if applicable):

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

Section 7: Child Foster Care Home Option

Would you like information about providing children's foster care in your CFH? ☐ Yes ☐ No

Section 8: Application Verification

My signature below means that I hereby request recertification as a certified family home.
My signature below means that I hereby confirm that all staff and 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.
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 certified 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 herein is true and correct to the best of my knowledge.

Provider Signature: ______________________________ Date: ____________________