# REQUEST FOR NEW ADMISSION

*Submit to a certifying agent for the admission of a first or second resident*

## 1. CFH Provider and Home Information.

| | | |
|---|---|---|
| Full Legal Name: | | Certificate No.: |
| Phone Number: | Email: | |
| Training/Education/Experience of the Provider to Meet Needs of CFH Residents: | | |
| If the provider works outside the home, is the provider immediately available to consult with staff?<br>☐ Yes ☐ No ☐ N/A Employer: _____ Work Phone:_____ | | |
| Number of Non-Clients Living in the Home (exclude CFH residents) | Adults: | Children: |
| Care Needs of Non-Clients, if any: | | |

| Rooms For CFH Resident(s) | Square Footage | Names of Prospective/Current Occupants |
|---|---|---|
| Sleeping Room #1 | | |
| Sleeping Room #2 | | |
| ☐ Attach a copy of the home's floor plan that identifies the rooms above and evacuation routes. | | |

## 2. Substitute Caregivers. *Must be adults with current qualifications.*

| Substitute Caregiver Name | Age | Expiration Date of CPR | Expiration Date of First Aid | Date of DHW Background Clearance | Date of Medication Course |
|---|---|---|---|---|---|
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## 3. Current and Prospective Residents.

### Resident #1:

| | | |
|---|---|---|
| Full Legal Name: | | Date of Birth: |
| Sex: ☐ Male ☐ Female | Relationship to Provider: | |
| Diagnoses/Behaviors: | | |
| Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision): | | |
| Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay | | |
| Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No | | |
| Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No<br>If Yes, Representative Name: _____ Phone:_____ | | |

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|---|
| Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No<br>If so, please describe and how the home can accommodate them: |

## Resident #2 (if applicable):

| | |
|---|---|
| Full Legal Name: | Date of Birth: |
| Sex: ☐ Male ☐ Female | Relationship to Provider: |
| Diagnoses/Behaviors: | |
| Hours of Daily Direct Care Needed (i.e., 1:1 services—excludes passive supervision): | |
| Care Payment: ☐ DD Waiver ☐ Self-Directed ☐ A&D Waiver/MMCP/IMPlus ☐ Private Pay | |
| Any unstable health issues that require 24-hour ongoing care from a licensed nurse? ☐ Yes ☐ No | |
| Does the resident have a legal guardian or power of attorney for healthcare? ☐ Yes ☐ No<br>If Yes, Representative Name: _____ Phone:_____ | |
| Does the resident have any physical impairments? (non-ambulatory, blind, etc.): ☐ Yes ☐ No<br>If so, please describe and how the home can accommodate them: | |

| **4. Admission(s) Request and Decision** | Resident #1 | Resident #2 (if applicable) |
|---|---|---|
| Current or Prospective CFH Resident?<br>• If an existing resident, mark "Current" and skip the remainder of the column | ☐ Current<br>☐ Prospective | ☐ Current<br>☐ Prospective |
| Results of history & physical examination conducted within last 12 months with list of current prescribed medications and treatments | ☐ Attached | ☐ Attached |
| Plan of service from the previous residential healthcare setting where the resident lived within the last 6 months, if applicable | ☐ Attached | ☐ Attached |
| Emergency Admission?<br>• Immediate risk of homelessness<br>• Admission outside of normal business hours (Monday – Friday, 8am – 5 pm) | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| Anticipated Date of Admission into the Certified Family Home | | |
| Provider Signature (signifying request for approval of admission) | Date | |
| Certifying Agent Approval (signature and date if approved; consult with program manager if denied) | | |