



Application Date: _____

Date Received: _____

ADULT FAMILY HOME CERTIFICATION APPLICATION

I. IDENTIFYING INFORMATION

Applicant #1:

Name: _____
Last First Middle Initial (Maiden Name or AKA)

Home Telephone # Work Telephone # Cell Number #

Email Address: _____

Home Address: _____
(Street, City, State, Zip, County)

Date of Birth Social Security # Drivers License #

Applicant #2:

Name: _____
Last First Middle Initial (Maiden Name or AKA)

Home Telephone # Work Telephone # Cell Number #

Email Address: _____

Date of Birth Social Security # Drivers License #

Relationship to Applicant #1: _____

Directions to Home: _____

If less than five years in home, list previous address: _____

Have you ever lived in another state? If yes please list state and dates lived there: _____

Children (if married, give full name):

| Name | Date of Birth | Current Mailing Address |
|-------|---------------|-------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Other persons living in home: | Date of Birth | Relationship |
|-------------------------------|---------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has either applicant ever been the subject of an investigation relating to the care/well being of their children? _____ If so, please explain: _____

By signing this application, you are giving this agency the right to pursue further investigation into this matter for purposes of certification.

II. EDUCATION

Applicant #1: Years completed: _____
Elementary High School Technical College

Applicant #2: Years completed: _____
Elementary High School Technical College

III. EMPLOYMENT

1. List most recent full and part-time work including self-employment and child care:

| <u>Applicant #1:</u> | <u>Applicant #2:</u> |
|----------------------------|----------------------|
| Employer's Name: _____ | _____ |
| Address: _____ | _____ |
| Job Title: _____ | _____ |
| Telephone: _____ | _____ |
| Dates of Employment: _____ | _____ |

2. Days worked (name the days): _____

3. Hours worked – From: _____ To: _____ From: _____ To: _____

4. TYPE OF HOME:

| | | | |
|---|-----------------|-------------------|--------------------|
| _____ House | _____ One Story | _____ Two Story | _____ Split Level |
| _____ Mobile Home | | | |
| _____ Apartment/Duplex/Condominium: | | _____ First Floor | _____ Second Floor |
| _____ Number of Rooms | | | |
| _____ Number of Bedrooms | Location: | _____ First Floor | _____ Second Floor |
| | | _____ Basement | |
| _____ Number of Bathrooms | _____ # of Full | _____ # of Half | |
| (minimum of 1 bathroom per 8 household members) | | | |

Bedroom size certification standard: 80 square feet/resident in single occupancy bedrooms; 60 square feet/per resident in shared occupancy bedrooms; and 100 square feet if resident uses a wheelchair. Bedrooms must have an approved window.

5. (a) Do you or anyone else smoke in your home? Yes No
 (b) Do you or anyone in your home consume alcohol in your home? Yes No

6. Do you have pets in your home? Yes No

If yes: Number and type of pets Date of Rabies Vaccinations

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

(Please provide a copy of the vaccination record of your pet/s)

7. Is your home wheelchair accessible? Yes No

8. Please describe any other special adaptations (i.e., ramps, handrail, roll-in shower, etc.)

9. Does anyone in your home speak any language other than English, including sign language?

Yes No If yes, what language is spoken and by whom? _____

VII. HEALTH/MEDICAL/CRIME CONVICTION INFORMATION

Applicant #1:

Name of physician(s): _____

Address/Phone: _____

Applicant #2:

Name of physician(s): _____

Address/Phone: _____

1. Describe any health problems: _____

2. Are any household members regularly taking any medications: Yes No
Please explain: _____

3. A conviction record will have no bearing on approval unless the conviction is for a crime reasonable related to your ability to provide care. Have you or anyone in your household ever been accused and/or convicted of a crime substantially related to caring for a dependent population, including children? Yes No
If 'Yes', please explain: _____

VIII. PERSONAL EXPERIENCE AND TRAINING

1. Have you provided care for adults in your home prior to this application?
Applicant #1: Yes No
Applicant #2: Yes No
2. Have you ever been denied licensure or certification of any kind to provide care or services to persons not related to you or, has such licensure or certification ever been revoked or suspended?
Applicant #1: Yes No
Applicant #2: Yes No
If "yes", please identify the licensing or certifying agency and type of license or certificate: _____

3. What training have you had that you believe will help you in understanding and providing adult family care? (i.e., nurses aid experience, first aid, CPR, fire safety training, etc.)
Applicant #1: _____
Applicant #2: _____
4. What past experiences – work, volunteer, or life experiences – do you believe will help qualify you to provide this type of care? _____

5. Why do you want to be certified to provide adult family care? _____

6. Do you want to be certified to provide care for one or two adults?
7. How did you learn about adult family home care? _____

8. Do you have a support system in place for this type of work? (i.e. family members, neighbors who can be called in an emergency, etc.) Please describe: _____

9. In providing adult family care, which of the following adults would you prefer to work with?

- Persons who are elderly
- Persons who have physical disabilities
- Persons who have developmental disabilities
- Persons who have mental health issues
- Persons in recovery from alcohol/drug dependence

10. In providing adult family care, would you prefer to work with adults who are:

- | | | |
|--|--|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> 18-25 | <input type="checkbox"/> 80+ |
| <input type="checkbox"/> Female | <input type="checkbox"/> 25-65 | <input type="checkbox"/> No age preference |
| <input type="checkbox"/> No preference | <input type="checkbox"/> 65-80 | <input type="checkbox"/> Long-term |
| <input type="checkbox"/> Short term | <input type="checkbox"/> Respite care only | <input type="checkbox"/> Respite available |

11. For the purposes of matching potential residents in your home, please list your hobbies and leisure time activities:

Applicant #1: _____

Applicant #2: _____

12. Religious information: The completion of religious questions is voluntary and has no bearing on approval of this application. There are some foster adults who express preferences for being placed in homes where the foster sponsors are of a certain denomination.

| | Applicant #1: | Applicant #2: |
|---|---------------|---------------|
| Religion | _____ | _____ |
| Church Affiliation | _____ | _____ |
| Is church attendance regular or occasional? | _____ | _____ |

Will you agree to either directly provide transportation or provide transportation accommodations for which you are responsible to residents wishing to attend a church function if denomination is different from yours? _____

IX. FINANCIAL

Financial information: Medicaid Waiver Standards for Wisconsin Adult Family Homes Under SPC 202.04 (3) states:

The sponsor shall present evidence of having or having access to sufficient financial reserves to meet the needs of all residents and of all members of the household for whom the sponsor is financially responsible and to ensure the adequate functioning of the home for a period of at least 30 days without receiving payment for the care of any resident.

| | | |
|----------------------------|---------------|----------|
| Annual Gross Income | Applicant #1 | \$ _____ |
| | Applicant #2 | \$ _____ |
| Other income (specify) | _____ | \$ _____ |
| | _____ | \$ _____ |
| | Total: | \$ _____ |

INDIVIDUAL QUESTIONNAIRE

1. Are you permanently settled? Explain:
2. Describe your relationships with your neighbors, extended family, and friends:
3. Describe your housekeeping habits.
4. What tasks might you expect a member to perform while living in your home?
5. Do you have any restrictions on the use of your home or furniture by an Adult Family Home resident? Explain:
6. Do you own any household items that could be considered dangerous? (i.e, medication, firearms, toxic chemicals, etc.)? What precautions will you take in regard to these items?
7. How do you resolve disagreements with others?
8. Are you willing to work with and communicate with the member's family, guardian, and interdisciplinary team? Please explain?
9. What would you do if you disagree with something that the interdisciplinary team or adult family home coordinator requested that you do?

10. Describe a situation where you became upset. How did you handle it?
11. How do you behave when you become worried or anxious?
12. What are your expectations in return for providing care for an adult with needs?
13. What do you think the most important thing to remember when caring for a member?
14. What would you do if you asked your member to do something and he/she refused?
15. What would you do if your member hit, spit at, or bit you? At a family/household member?
16. What would you do if he/she were verbally abusive?
17. What do you think may be difficult about being a Adult Family Home caregiver?
18. Describe experiences in sharing your home: other than with your family.
19. Describe any relevant experiences working with others that you wish to share.

20. Are you willing to attend appropriate trainings, workshops, medical appointments, and counseling sessions, etc., with regard to potential placements in your home?

21. Describe yourself/household – personality, activities, general attitude (positive, negative), and interests. Describe your spouse.

22. Happy with life? Satisfactions-disappointments?

23. Tell me about losses in your life and how you have deal with them.

24. Have you or anyone in your household ever been diagnosed with a mental health condition? If yes, please explain.

25. Have you or anyone in your household ever been diagnosed with a dependence on drugs or alcohol? If yes, please explain.

26. Do you or anyone in your household use drugs or alcohol currently?

27. Have you had any past physical health issues that would interfere with your capacity to provide for a members care?

28. Do you currently have any physical health issues that would interfere with your capacity to provide for a members care?

29. What are the written and unwritten rules of the household?

30. Why do you want to become a AFH Provider?

31. What do you think you will enjoy most about being a AFH Provider?

32. What is your definition of confidentiality?

33. Are there any issues, concerns, or situations that you feel NorthernBridges should know about you and/or your family?

Signature of AFH Applicant

Date

Please return completed application to:

Sue Joel
Adult Family Home Coordinator
NorthernBridges
15954 River's Edge Drive, # 300
Hayward, WI 54843