Application Date: ____________
Date Received: ____________

ADULT FAMILY HOME APPLICATION
(CORPORATE/COMMUNITY CARE)

I. IDENTIFYING INFORMATION

Agency:

Agency: ____

Agency Mailing Address: ____________________________________

____
City State Zip Code County

Email Address: ____

Agency Telephone #: ______________________________________

Agency Contact: ____

Home:

Home Name: ____

Home Street Address: ______________________________________

____
City State Zip Code County

Email Address:____

Home Telephone #: ____

Manager/Administrator: ____________________________________

Directions to home: ____

____

____

____

____

II. INSURANCE

Liability Insurance. *A) VEHICLE. Applicants who plan to transport members in their vehicles shall have valid driver's licenses and shall provide NorthernBridges (NB) with documentation of liability insurance coverage. NB expects that providers will follow proper protocol to ensure that all drivers have gone through a drivers license check and that adequate insurance coverage is in place. B) HOME. Applicants shall provide NB with documentation of sufficient facility insurance coverage to provide liability protection. C) PROFESSIONAL. Applicants shall provide NB with documentation of sufficient professional liability insurance coverage to ensure protection.*

PLEASE PROVIDE A DECLARATION PAGE OF YOUR INSURANCE POLICIES.

1. Auto____
2. Home ____
3. Professional Liability____
4. Workmen's Compensation Insurance_____________________________________

Will you agree to either provide direct transportation or transportation accommodations for which you would be responsible for a resident who may be unable or unwilling to transport themselves? ☐ Yes ☐ No

III. Information About The Home

1. Do you own or rent the home? Own ☐ Rent ☐

2. Location: Rural Home ____________________City ____________________
   Nearest town ____

3. 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 _____ 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.

4. Will smoking be allowed in the home? ☐ Yes ☐ No

5. Will the agency have pets in the home? ☐ Yes ☐ No
   If yes: Number and type of pets Date of Rabies Vaccinations

   ____________________________ ____________________________
   ____________________________ ____________________________
   ____________________________ ____________________________

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

6. Is the home wheelchair accessible? Yes ______ No ______

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

____

____

IV. EXPERIENCE

1. Do you operate any other residential homes that serve adults?

   Yes _____ No _____

2. Have you ever been denied licensure or certification of any kind to provide care or services to persons or, has such licensure or certification ever been revoked or suspended?

   Yes _____ No _____

   If "yes", please identify the licensing or certifying agency and type of license or certificate:

   ____

   ____

3. Check each area that best describes the individuals that you will be providing care to in this home:

   ______ Developmentally Disabled ______ Physically Disabled

   ______ Frail Elderly ______ Mentally Health Issues

   ______Persons in Recovery from Alcohol/Drug Dependence

4. Check each area that best describes the individuals that you will be providing care to in this home:

   ______ Male 18 – 25 ______

   ______ Female 25 – 65 ______

   65+ ______

5. What training have you had that you believe will help you in understanding and providing adult family care? ____

____

____

6. What past experiences – work, volunteer, or life experiences – do you believe will help qualify you to provide this type of care? ____

____

____

____

V. FINANCIAL

SPC 202.04 states: The sponsor may be requested to 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.

Please check all other sources of income that could be utilized:

_____ Savings _____ Line of credit _____ Loan

_____Purchase contract _____ Other assets

VI. OTHER INFORMATION

List the following information for any individuals who work or live in the home and are not a resident (please provide copies of background checks for any individuals 10 years of age or older).

Last name, First name, Middle initial	**Relationship to licensee**	**D.O.B**	**Date of last background check**

VII. RERFENCES

Personal References: Please provide the names and addresses of three unrelated people who can be contacted to provide a person reference for your application. This application will be returned if no address is supplied.

1. ____
Name Address Telephone Relationship

2. ____
Name Address Telephone Relationship

3. ____
Name Address Telephone Relationship

VII. PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. Business plan
2. Mission statement, and a Program Statement
3. Vision and values
4. Company policy and procedures (example – facility abuse prevention plan, vulnerable adult abuse prevention plan and internal reporting procedures, medication administration policy, psychotropic medication policy, staffing patterns, grievance policy for members/residents, resident/members rights)
5. Requirements for staff trainings
6. Staff physicals, TB testing, and background checks

VIII. SIGNATURE(s)

In completing this application, we (I) understand there is no guarantee by the NorthernBridges that an adult will be placed in the home. We (I) also understand that the NorthernBridges is free to consult persons or agencies disclosed on this form or through certification interviews. The information contained in this questionnaire is true and correct to the best of our (my) knowledge.

Applicant #1: ________________________________ ____________________
Signature Date

Applicant #2: ________________________________ ____________________
Signature Date

Please return completed application to: Sue Joel
Adult Family Home Coordinator
NorthernBridges
15954 River's Edge Drive, # 300
Hayward, WI 54843