

ADULT FAMILY HOME PROVIDER APPLICATION/CHANGE FORM

INSTRUCTIONS: Type or print your information on this application. If a question does not apply to your application, write "N/A" in the field. If you have more than one home, please fill out a second application form. **Electronic Copies** of this application can be found at www.northernbridges.com.

Date:

Legal Name(s)		Home Telephone #	
Address: (Street, City, State, Zip Code)		Cell Telephone #	
Directions to home		Is the house for which you are applying for certification your primary residence? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		County your AFH is located in: Ashland (A), Barron (BA), Bayfield (BY), Burnett (BU), Douglas (D), Iron (I), Polk (PO), Price (PR), Rusk (R), Sawyer (S), Washburn(W) _____	
Email Address	Occupation	Target Populations Served: (Check all that apply) <input type="checkbox"/> Frail Elders - FE <input type="checkbox"/> Physical Disabilities - PD <input type="checkbox"/> Developmental Disabilities – DD	
Fax Number	Work Number		
Type of AFH <input type="checkbox"/> Traditional 1 or 2 bed AFH <input type="checkbox"/> Traditional 3 or 4 bed AFH <input type="checkbox"/> Corporate 1 or 2 bed AFH		Number of Individuals certified or licensed for	
Specialty Populations Served: (Check all that apply) <input type="checkbox"/> Alzheimer/Dementia <input type="checkbox"/> AODA <input type="checkbox"/> Autistic <input type="checkbox"/> Bariatric <input type="checkbox"/> Mental Health <input type="checkbox"/> Behavioral <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____		Check all that apply: <input type="checkbox"/> Provider willing to support resident with urine incontinence <input type="checkbox"/> Provider willing to support resident with bowel incontinence <input type="checkbox"/> Provider willing to do transfers <input type="checkbox"/> Provider home is wheelchair accessible <input type="checkbox"/> Provider flexible in requiring outside day programming <input type="checkbox"/> Provider is licensed for children's foster care <input type="checkbox"/> Provider is a respite provider only <input type="checkbox"/> Provider is respite and AFH provider	
List name and age of individuals placed in your home.	List name, age and relationship to Provider of any other individuals living in your home.	Have you ever been denied licensure, certification or approval of any kind to provide care or services or has such licensure, certification or approval ever been revoked or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attach copy of your AFH certificate or license and documentation of homeowners or renters insurance and auto insurance.
Describe any special adaptations to your home:			
Are you or a family member past or current employees of NorthernBridges? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes – please list:			

In receiving this application, NorthernBridges relies on the truth of all the following statements:

All information entered in this Provider Application is accurate and complete. If any of the information changes Provider will timely notify NorthernBridges of such change. Providing false information or omitting information may result in contract denial or termination.

NOTIFICATION OF CHANGES: You must inform NorthernBridges of any Provider additions and/or changes in licensure, certification, and physical service location or payee address.

Failure to notify NorthernBridges of any changes may result in:

- **Misdirected payment**
- **Loss of certification**
- **Other actions**

Authorized Signature of Provider:	Date:
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