



## Certified 1-2 Bed Adult Family Home Application

Submit your application using one of the following methods:

Email: [ProviderDevelopment@inclusa.org](mailto:ProviderDevelopment@inclusa.org) • Fax: (608) 785-5336, Attn: CR/PR Provider Development

Mail: Attn: CR/PR Provider Development, 1407 Saint Andrew Street, Ste. 100, La Crosse WI 54603

**\*\*ONLY COMPLETE APPLICATIONS WILL BE ACCEPTED\*\***

<b>Application Date:</b>		<b>Date Received by Office:</b>	
<b>APPLICANT INFORMATION</b>			
Last Name:		First Name:	Middle Initial:
Maiden Name/Also Known As:			
Date of Birth:		Social Security Number:	
Driver License Number:			
Home Phone:		Cell Phone:	Work Phone:
Email Address:			
Address:			
City:		State:	Zip Code:
If you have resided at this address less than five (5) years, list previous address below:			

<b>ADULT FAMILY HOME INFORMATION</b>	
If you are currently certified by another entity other than Inclusa please list the entity and certification date:	
<b>You will need to submit a copy of your current certificate with your application.</b>	
If you are not currently certified, are you applying to be certified for <input type="checkbox"/> one (1) or <input type="checkbox"/> two (2) adults with disabilities?	
<b>Additional Information</b>	
Are you applying to provide care for a specific individual?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, Individual's name:	
Do you live in the home you are seeking to have certified?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please tell us why you want to become an Adult Family Home Provider:	

<b>CERTIFICATION INFORMATION</b>			
As an Adult Family Home Provider, would you prefer to work with members who are (check all that apply)?			
Male <input type="checkbox"/>	Age: <input type="checkbox"/> 18-25		
Female <input type="checkbox"/>	<input type="checkbox"/> 25-65		
No Preference <input type="checkbox"/>	<input type="checkbox"/> 65-80		
	<input type="checkbox"/> 80+		
	<input type="checkbox"/> No Preference		
Inclusa provides services for individuals who may have one or more of the following disabilities. Please indicate which individuals you are interested in serving (check all that apply):			
<input type="checkbox"/> Intellectual Disabilities	<input type="checkbox"/> Physical Disabilities	<input type="checkbox"/> Frail Elderly	<input type="checkbox"/> No Preference
<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Alcohol or Other Drug Addiction	<input type="checkbox"/> Mental Health	

Have you or any household member even been denied licensure, certification, etc. to provide care or services?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, list date and explain:
Have you or any household member ever provided care as a certified or licensed provider in a home setting prior to this application?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, has licensure, certification, etc. ever been revoked or suspended? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list date of revocation/suspension and explain:
Have you ever surrendered any type of licensure, certification, etc.?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, list date of surrender and explain:

ADDITIONAL APPLICANT INFORMATION					
Education					
High School		Highest Grade Completed		Degree	
Tech College or University		Highest Year Completed and Major		Degree	
List any current or previous licenses or certifications held by you (daycare, adult family home, CPR, First Aid, etc.):					
Current Employment					
Employer's Name:					
Employer's Address:					
Job Title:					
Employer's Telephone Number:					
Dates of Employment:					
Work Schedule:					
Former Employment: (List the last five (5) years)					
Employer Name and Position		Dates of Employment		Reason for Leaving	
Military Service					
Branch	Dates Served	Current Status			
		Active		Discharged: List Type of Discharge	
		Yes <input type="checkbox"/> No <input type="checkbox"/>			
Marital Status and Household Members					
Current Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced – Provide the following for prior marriage(s): Former Spouse's Full Name: _____ Dates of Marriage: From: _____ To: _____				
Children (if child is married, give full name) Please use a separate piece of paper if needed					
Full Name	Age	Where They Currently Live			
List any individuals living in your household or who are frequent guests (persons who visit the home weekly or more often) not listed above. Use additional paper if more space is required.					

Full Name		Age	Relationship to Applicant	
<b>Spouse/Partner Information</b> (If no spouse/partner, skip to Information about Your Home section)				
Last Name:		First Name:		Middle Initial:
Maiden Name/Also Known As:				
Date of Birth:		Social Security Number:		
Driver's License Number:				
Home Phone:		Cell Phone:		Work Phone:
Email Address:				
Address:				
City:		State:		Zip Code:
If resided at this address less than five (5) years, list previous address below:				
<b>Spouse/Partner Education</b>				
High School		Highest Grade Completed		Degree
Tech College or University		Highest Year Completed and Major		Degree
List any current or previous licenses or certifications held (including daycare, adult family home, CPR, First Aid):				
<b>Spouse/Partner Current Employment</b>				
Employer's Name:				
Employer's Address:				
Job Title:				
Employer's Telephone Number:				
Dates of Employment:				
Work Schedule:				
<b>Spouse/Partner Former Employment:</b> (List the last five (5) years)				
<b>Employer Name and Position</b>		<b>Dates of Employment</b>		<b>Reason for Leaving</b>
<b>Spouse/Partner Military Service</b>				
<b>Branch</b>	<b>Dates Served</b>	<b>Current Status</b>		
		Active		
		Discharged: List Type of Discharge		
		Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Spouse/Partner Marital Status and Household Members</b>				
Previous marriage(s):	Yes <input type="checkbox"/> No <input type="checkbox"/>			
	If yes, provide the following for prior marriage(s):			
	Former Spouse's Full Name:			
	Dates of Marriage: From: To:			
<b>Spouse/Partner's children not listed under Applicant information (if child is married, give full name)</b>				
<b>Full Name</b>		<b>Age</b>	<b>Where They Currently Live</b>	

INFORMATION ABOUT YOUR HOME			
Do you own or rent your home?	Own <input type="checkbox"/> Rent <input type="checkbox"/>	Is this home your primary residence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you wish to certify a home other than your primary residence, please list the address of the home to be certified:			
Do you or any household members have a business in your home?		Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe the business:	
Are there two exits from the First/Main Floor to the outside?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Exterior Home Information (please check one):</b> To get into the home: <input type="checkbox"/> Accessible (0-1 steps) <input type="checkbox"/> Semi-accessible (2-4 steps) <input type="checkbox"/> Non-accessible (More than 4 steps)		<b>Interior Home Information:</b> To move around inside the home: <input type="checkbox"/> Accessible (no steps to get to needed area(s) of home) <input type="checkbox"/> Semi-accessible (a couple to half flight steps to get around inside the home) <input type="checkbox"/> Non-accessible (full flight of stairs to get to needed area(s) of the home)	
Does your home have well water? <i>AFH providers are required to have well water tested prior to certification and annually thereafter</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>How did you learn about Community Link, Inc. (CLI) Adult Family Home Program? (Check all that apply)</b>			
<input type="checkbox"/> Know a Member (individual enrolled in Inclusa) <input type="checkbox"/> Know an AFH Provider <input type="checkbox"/> Personal experience with CLI, please specify: <input type="checkbox"/> Employment through another agency, please specify: <input type="checkbox"/> Media: <input type="checkbox"/> Newspaper <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Internet <input type="checkbox"/> Other, please describe:			

REFERENCES					
Please include two (2) <b>unrelated</b> people (including at least one employer) who have known you for at least a year and two (2) <b>relatives</b> that can be contacted to provide a reference for you:					
1	Name:		Relationship:		
	Address				
	City:		State:	Zip Code:	
	Telephone Number:		Email Address:		
2	Name:		Relationship:		
	Address				
	City:		State:	Zip Code:	
	Telephone Number:		Email Address:		
3	Name:		Relationship:		
	Address				
	City:		State:	Zip Code:	
	Telephone Number:		Email Address:		
4	Name:		Relationship:		
	Address				
	City:		State:	Zip Code:	
	Telephone Number:		Email Address:		

#### **RELEASE OF INFORMATION AND APPLICATION ATTESTATION**

I hereby give permission to Inlusa to contact the references provided and to obtain relevant medical, financial, criminal, and employment information needed to process the application or certification, if approved. The Authorized Representative of Inlusa is free to verify any information on the application form and contact other agencies such as Department of Health and Social Services, Human Services Departments and 51.42 Agencies.

In completing this application, I understand there is no guarantee by the agency that certification is guaranteed or a member will be placed in the home. I also understand that Inlusa is free to consult persons or agencies named herein. The information contained in this application is true and correct to the best of my knowledge. Providing false or incomplete information will result in Inlusa declining certification as an Adult Family Home.

<b>Applicant Signature:</b>		<b>Date:</b>	
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