Please print neatly and fill out each section using N/A if not applicable.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Identifying Information**  ***Applicant 1*** | | | | | | | |
| Last Name | | | First name | | | MI | Maiden Name or AKA |
| Date of Birth | SS# | | | Cell | | | Fax |
| Marital Status  Single Married Divorced Widowed | | | | | Home Phone | | Email Address |
| Highest level of Education  High School Technical School College Degree | | | | | Name of College/Area of Study | | |
| Employer Name | | | | | Your Job Title | | |
| Work Phone | | May we call you at work?  Yes No | | | What hours do you work? | | Best time to call? |
| ***Applicant 2*** | | | | | | | |
| Last Name | | | First name | | | MI | Maiden Name or AKA |
| Date of Birth | SS# | | | Cell | | | Email Address |
| Marital Status  Single Married Divorced Widowed | | | | | Home Phone | |  |
| Highest level of Education  High School Technical School College Degree | | | | | Name of College/Area of Study | | |
| Employer Name | | | | | Your Job Title | | |
| Work Phone | | May we call you at work?  Yes No | | | What hours do you work? | | Best time to call? |

|  |
| --- |
| Name of Adult Family Home Street Address City State Zip County |
| Mailing Address (if different) |
| Does GPS find your home? Yes No  Directions to Home: |

Do you live in the home you are seeking to have certified? 󠄀Yes No

**Information about other household members**   
(If more space is needed, use additional paper)

***Children***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name (oldest first)** | **Date of Birth** | **Sex** | | **Living in Home** | |
| **Male** | **Female** | **Yes** | **No** |
|  |  |  |  |  |  |
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***Other Persons Living in or are Frequent Visitors of the Home***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Date of Birth** | **Sex** | | **Relationship** |
| **Male** | **Female** |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Does anyone in your home speak any language other than English?  Yes No American Sign Language? Yes No | If yes, what other language(s)? |
| Do you allow smoking in the home? Yes No  Do household members smoke in the home? Yes No | If so, is there a designated area for smoking?  No Yes, Where? |

**Information about your home**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Location Description  City Rural Farm | | | Nearest Town: | | | | | How many years have you lived at this address? | | | |
| Do you own or Rent?  Own Rent | | | Previous Address: | | | | | | | | |
| Type of Home  House: 1 story 2 stories Other       Apartment: first floor second floor Mobile Home | | | | | | | | | | | |
| How is water supplied to your home?  Public Water Supply Private Well (testing required) | | | | | | | How many rooms in the home? (include bed, bath and laundry rooms) | | | | |
| Number of Bedrooms | | | | | | | Number of Bathrooms | | | | |
| First Floor | | Second Floor | | | Other | | First Floor | | Second Floor | | Other |
|  | |  | | |  | |  | |  | |  |
| Is your home wheelchair accessible?  Yes No | | | | | | Describe any other special adaptations in your home (ramps, etc): | | | | | |
| Are there pets in your home?  Yes No | Do you allow members to have pets in your home?  Yes No | | | Type of Pet | | | | | | Expiration Date of Vaccination | | |
|  | | | | | |  | | |
|  | | | | | |  | | |
|  | | | | | |  | | |

**Information about available transportation**

|  |  |
| --- | --- |
| Do you have reliable transportation available?  Yes No | Is your Vehicle Handicap Accessible? |
| List other persons in the household with a valid driver’s license who are willing to provide transportation | |
| 1.       2. | |

**Experience/Training**

|  |  |
| --- | --- |
| Are you applying to provide care for a specific person? Yes No If Yes, relationship to person? | |
| Have you provided care for adults in your home previously? | |
| Applicant 1: Yes No | When? |
| Applicant 2: Yes No | When? |
| If no, how did you learn about our program? | |
| If you are currently licensed or certified by another entity other than Inclusa please list the entity and effective date:    **You will need to submit a copy of your current license or certificate with your application.** | |
| Have you ever been denied licensure or certification of any kind to provide care and services, or has such licensure or certification been revoked or suspended? | |
| Applicant 1: Yes No | When? |
| If yes, please identify the licensing or certifying agency and type of license or certificate: | |
| Applicant 2: Yes No | When? |
| If yes, please identify the licensing or certifying agency and type of license or certificate: | |

**Preferences**

|  |  |
| --- | --- |
| Do you want to be certified for **one or two adults?**  One Two Shared Room? | Would you prefer to work with a **specific Gender?**  Male Female No Preference |
| What **age group** would you prefer to work with?  18-25 25-65 65 & older No preference | What **populations** would you prefer to provide care for?  Developmentally Disabled Physically Disabled  Elderly Mental Health  Other: |
| Are you interested in providing **short-term (respite)** care to an adult in your home?  No Yes In an Open bed In an Additional Bed | |

**References**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | | Relationship: | |
| Address: | City: | State: | Zip Code: |
| Phone: | Email: | | |
| **Name:** | | Relationship: | |
| Address: | City: | State: | Zip Code: |
| Phone: | Email: | | |
| **Name:** | | Relationship: | |
| Address: | City: | State: | Zip Code: |
| Phone: | Email: | | |

**Other Business/Services**

|  |
| --- |
| Do you use your home for business purposes or provide other services within your home?  Yes No If yes, describe: |

**Financial Information**

Medical Assistance – Per Wisconsin State standards, Adult Family Home Providers 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 provider is financially responsible and to ensure the adequate functioning of the home for a period of at least 30 days without receiving pay for the care of any residents.

|  |
| --- |
| Net monthly family income |
| Sources of Income (wages, Social Security, interest, child support etc.) Do not list individual dollar amounts. |
|  |
|  |
|  |

The Applicant is responsible for notifying Inclusa, in writing, of any changes in the information provided in the application.

I understand there is no guarantee by the certifying agency that a member will be placed in my home.

I give permission to contact the references provided and in addition, obtain any medical, psychiatric, financial, criminal, and employment information needed to process this application. The certifying agency is free to verify any information on the application form and to contact other agencies such as the Department of Health and Family Services, Human Services Departments and 51.42 Agencies.

I understand that the information disclosed will be used for the sole purpose of investigating my application for my Adult Family Home certification.

The statements in my application are, to the best of my knowledge, true, correct and complete.

Applicant or Designee:      

Signature Date

Applicant 2 or Designee:

Signature Date

Further, I attest that I have read and will comply with all applicable requirements as stated in the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family homes. <http://www.dhs.wisconsin.gov/publications/P0/P00638.pdf>

|  |  |  |
| --- | --- | --- |
| Applicant 1 Signature |  | Date |
| Applicant 2 Signature |  | Date |

***Send your completed Adult Family Home Certification Application to:***

**Submission Options:**

Mail: AFH Prog Asst Email: [shelli.rogge@inclusa.org](mailto:shelli.rogge@inclusa.org)

Inclusa

3349 Church St Suite 1 Fax: 715-514-3147

Stevens Point WI 54481