Owner Occupied Adult Family Home Certification Application

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# / DL#			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# / DL#			
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?

Name of Adult Family Home	Street Address	City State Zip	County
Mailing Address (if different)			

Does GPS find your home? ☐Yes ☐No Color of Home:_____ Outside covering: ☐Siding ☐Brick
Located on what side of the road-check one: ☐North ☐South ☐East ☐West
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
1.		☐	☐	☐	☐
2.		☐	☐	☐	☐
3.		☐	☐	☐	☐
4.		☐	☐	☐	☐

Other Persons Living in or are Frequent Visitors of the Home

Name	Date of Birth	Sex		Relationship
		Male	Female	
1.		☐	☐	
2.		☐	☐	

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?	How many rooms in the home? (include bed, bath and laundry rooms)
☐ Public Water Supply ☐ Private Well (testing required)	

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
		1.	
		2.	
		3.	

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	Would you prefer to work with adults who are: ☐ 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 Specialty:
Are you interested in providing short-term (respite) care to an adult in your home? ☐ Yes ☐ No	

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.
1.
2.
3.

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:

Email: shelli.rogge@inclusa.org

Fax: (715) 514-3147

Mail: Shelli Rogge
Inclusa
3203 Stein Blvd., Suite 1
Eau Claire, WI 54701