



# Adult Family Home (AFH) Program Statement

Before an applicant may be certified and/or at the time of certification renewal, the applicant must submit a program statement in accordance with Medicaid Waiver Standards for Adult Family Homes. Prior to any changes, the home shall revise its program statement and submit it to the AFH Program Manager for approval. The AFH Program Manager will either approve or deny this change within 30 days of receiving the notice. Completion of this form meets the requirements for Medicaid Waiver Standards.

Name of Adult Family Home:	
Address/City/State/Zip:	County:

<b>Target Groups(s) Served (check all that apply)</b>	
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Disability <input type="checkbox"/> Elderly <input type="checkbox"/> Mental Health Other: _____	
<b>Number of Individuals</b>	<b>Gender of Individuals</b>
<input type="checkbox"/> One Person <input type="checkbox"/> Two Persons    Is it a shared room? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No Preference
<b>Respite Services</b> (Requires an exception request and approval of the certifying agency)	
Is it your intent to provide <b>temporary respite</b> care in the home?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> In an Open Bed <input type="checkbox"/> In an Additional Bed	
<b>If yes</b> , describe the maximum number of temporary adults that may be in the home at any one time, a description of the bedroom space to be used for respite, frequency that the home may be used for respite care, if additional staff will be present and if this staff would be awake at night.	

<b>Accessibility of the Home</b>	
<input type="checkbox"/> Ambulatory <input type="checkbox"/> Semi-ambulatory <input type="checkbox"/> Wheelchair accessible	
<b>Description of the Home</b>	
Type of Home: <input type="checkbox"/> Two Story <input type="checkbox"/> One Story <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other: _____	
Location: <input type="checkbox"/> Town/City <input type="checkbox"/> Rural Area <input type="checkbox"/> Farm	
Is smoking allowed in or outside the home? <input type="checkbox"/> No <input type="checkbox"/> Yes    If Yes, Explain: _____	
Are there pets in the home? If yes, Type: _____	
<b>Resources Near the Home</b>	
<input type="checkbox"/> Church	<input type="checkbox"/> Grocery Store
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Convenience Store
<input type="checkbox"/> City Bus Line	<input type="checkbox"/> Library
	<input type="checkbox"/> Park
	<input type="checkbox"/> Movie Theater

How would you describe your Adult Family Home to a prospective resident? (1-2 sentences)

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What Activities will you use to incorporate the individual into community life? (include social, religious, cultural, political and intellectual) \_\_\_\_\_

Do you have a Wheelchair Accessible vehicle?  Yes  No

Describe the services and skills your home offers:

Provide any additional information that may help prospective residents make decisions related to the use of your home:

List other household members and their relationship with the sponsor:

\_\_\_\_\_  
*Applicant's Signature(s)*

\_\_\_\_\_  
*Date*

**Complete and Return This Form To:**

**Email: [InclusaAFH@inclusa.org](mailto:InclusaAFH@inclusa.org)**

**Fax: (608) 785-5336**

**Mail: Inclusa Provider Relations**

**Inclusa**

**2801 Hoover Rd., Unit 3**

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