STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR SOCIAL SERVICES

Application to Provide Adult Family Care

Applicant Name: _____ SSN:_____

Mailing Address: _____

Physical Address: _____

How long at this address? _____ Telephone Number: _____

If less than 5 years, give previous address:

_____

_____

Directions to the home:

_____

_____

Applicant's Birth Date: _____ Occupation: _____

Last Grade Completed: _____ Approx. Yearly Income: _____

Religious Preference: _____ Source(s) of Income: _____

Employer: _____

Health of Applicant: _____

Marital Status: (**mark one**) [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

If married, complete the following information about your spouse

Spouse's Birth Date: _____ SSN: _____

Occupation: _____ Approx. Yearly Income: _____

Last Grade Completed: _____

Religious Preference: _____ Source(s) of Income: _____

Employer: _____

Health of Spouse: _____

Other Members of the Household: (other than applicant and their spouse)

Name	Age	Relationship	Occupation/Grade in School

About You and Your Family

1. Are all members of your household willing to have an unrelated adult living in the home? Yes [ ] No [ ]

   If no, explain:

2. Have you ever provided services for or received services from the Department of Health and Human Resources? Yes [ ] No [ ]

3. Have you ever cared for persons who are elderly, blind, or disabled? Yes [ ] No [ ]
   If yes, explain:

4. Has anyone in your immediate family ever been arrested for or been involved in any crime or criminal activities? Yes [ ] No [ ]
   If yes, explain:

5. Has anyone in your immediate family ever been committed to a mental institution or been treated for a severe mental and/or emotional disturbance? Yes [ ] No [ ]
   If yes, explain:

6. Characteristics of adults you would prefer to be placed in your home: (mark all that apply):

Gender: [ ] Male [ ] Able to walk alone Age Range:

[ ] Female [ ] Able to walk with assistance Other:

[ ] Both

Characteristics of adults you would prefer NOT to be placed in your home:

7. Would you be willing to provide care in your home to a person who has been in a psychiatric/mental health facility and who requires additional supervision, including supervision of prescribed medication, to maintain a family life? Yes [ ] No [ ]

About Your Home

1. I live in (mark one)
   [ ] a home I own [ ] a home I rent [ ] an apartment [ ] other (specify)

   Note: If you rent your home, a written statement of permission to act as an AFC/ESC provider must be obtained from the property owner.

2. Number of rooms [ ] Number of bedrooms [ ] Number of bathrooms [ ]

3. Do you have a yard? Yes [ ] No [ ]

4. Does your home have an upstairs? Yes [ ] No [ ]

5. Does your home have a basement? Yes [ ] No [ ]

6. Water Supply & Plumbing: (mark all that apply)
   [ ] City water supply [ ] Tub bath

   [ ] Private water supply [ ] Shower bath

   [ ] Inside toilet

7. Does your home have electric lights? Yes [ ] No [ ]

8. What type of heating system(s) do you have:

9. Do you carry comprehensive liability insurance on your home? Yes [ ] No [ ]

10. Do you have adequate automobile insurance? Yes [ ] No [ ]

11. Do you own a reliable automobile? Yes [ ] No [ ]

12. Is there a household member with a valid driver's license? Yes [ ] No [ ]
    If not, explain how transportation will be provided?

13. Why do you and your family want to care for an adult in your home?

Additional Remarks:

Additional Requirements

You will be required to provide all of the following as part of the application process as an Adult Family Care/Adult Emergency Shelter Care provider. The necessary forms for each have been included in your application packet.

1. A completed application form
2. A completed Fire Safety Checklist
3. At least two (2) personal references (unrelated to you)
4. At least one credit reference (your electric company is recommended)
5. W-9 Information (IRS requires that information be on file)
6. Physician's statement completed for each adult member of your household

Agreement

I (or we) hereby certify that the information reported above is true and accurate to the best of my knowledge. Further, I (or we) agree that if this application is approved and a client is placed in our home, we will observe the regulations established by the West Virginia Department of Human Services. I (or we) understand that the West Virginia Department of Human Services is not liable for injuries or for property destroyed or damaged by or because of the Adult Family Care/Adult Emergency Shelter Care client.

_____ _____

Signature of Applicant Date Signed

_____ _____

Signature of Spouse Date Signed