WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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

Christina Mullins, MA
Acting Cabinet Secretary

Lorie Bragg
Commissioner

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 Human Services? 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 [ ] Female Age Range:

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

   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