Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Adult Foster Home (AFH-DD) License Application

Section 1 — Instructions

Applicants: Complete the License Application and other required licensing materials; pay the non-refundable fee; return all items to the County CDDP Office.

Application type *(Check all that apply)*:

☐ New ☐ Renewal ☐ Change of address ☐ Increase in capacity ☐ Change in provider

Classification: ☐ Level 1 ☐ Limited ☐ Provisional ☐ 2B ☐ 2M

Section 2 — AFH-DD Home Information

Name of applicant(s):_____Phone: _____

Name of co-applicant: _____Phone: _____

Site address _____

City, State, ZIP:_____County: _____

Mailing address *(if different)*:_____

Email address:_____

Number of individuals to be served in the home: _____

Number of persons living in the home, not counting individuals to be served: _____

Type of dwelling: ☐ House ☐ Apartment ☐ Mobile home Year: _____

☐ Own ☐ Rent/lease *(New applicants only: include a copy of the rental agreement.)*

Landlord/company name: _____

Address:_____Phone: _____

Physical features of the home *(check all that apply)*:

☐ Public water system ☐ Public sewer ☐ Septic tank ☐ Garbage service

☐ Well Water *(Test must be available for review)* ☐ Wheelchair ramp ☐ 2-story home

☐ Swimming pool ☐ Wood stove or fireplace ☐ Non use of wood stove or fireplace

What is the 2nd means of egress? ☐ Window ☐ Other: _____

Occupants: List **all** individuals living in the home or on the property. Include **individuals receiving care, caregivers, friends, family members, children, grandchildren, etc.** Must include Social Security number and date of birth for all, add an extra sheet if needed.

Full name	Relationship	Requires care	SSN	Date of birth
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

Do you have household pets? ☐ Yes ☐ No If yes, what kind? _____

Are they vaccinated for rabies? ☐ Yes ☐ No *(Rabies vaccinations must be available for review)*

Do you or others smoke? ☐ Yes ☐ No Do you permit individuals to smoke? ☐ Yes ☐ No

Do family members or individuals sleep in: ☐ Attic ☐ Basement ☐ Garage ☐ Living area

Do you live in the home? ☐ Yes ☐ No Number of days per week? _____

If you do not live in the home a minimum of 4 nights a week, you must have a Resident Manager live in the AFH-DD.

Section 3 — Provider information

Education: *(New applicants only)*

School name	City/State	Last grade completed	Year

Employment: *(New applicants only)* Describe previous paid, volunteer or family experience or training in working with individuals with development disabilities.

Name of employer	Address	Dates employed	Reason for leaving

Present employment: Are you currently employed outside the home? ☐ Yes ☐ No

Name and address of employer	Position held	Days worked	Hours worked

Personal emergency contacts:

Name	Phone number	Cell number

Professional emergency contacts *(another AFH-DD provider/resident manager on call)*

Name	Phone number	Cell number

Driver information		
State issuing license:	License number:	Expiration date:
Vehicle insurance company:		Insurance policy:

Licensed by other agency

Are you currently or have you ever been licensed or certified by any agency in Oregon to provide services to children or adults? ☐ Yes ☐ No If yes, please identify all that apply:

☐ Child Welfare ☐ Self-Sufficiency Programs ☐ Addiction & Mental Health Serv.

☐ APD (Aging & Physically Disabled) ☐ Veteran's Administration Services

☐ Proctor Care ☐ Multnomah County Adult Care ☐ Other agency: _____

Have you ever been licensed and/or certified in any other state? Identify state: _____

Type of service: Dates:

Have you ever had a license or certificate denied, suspended, revoked or conditions placed on your license? ☐ Yes ☐ No If yes, please explain (include agency and date(s) and reason):

List any other home operated by provider, spouse, co-applicant or resident manager

Address	County	Phone number of licensor/contact

Business information:
Are you currently operating your AFH-DD under a business license? ☐ Yes ☐ No

What is the name of your business? *(same name as on your Oregon Business License and on your Federal tax information)*: _____

Section 4 — Caregiver information

AFH-DD Caregivers: List all caregivers including Providers, Resident Managers, and respite caregivers.

Full name	Position	Social Security no.	Date of birth

*Providers, Resident Manager and <u>all</u> caregivers <u>MUST HAVE</u>: an approved Background Check and pass the Adult Foster Home Training Certification BEFORE PROVIDING ANY CARE. All **occupants** of the home over the age of 16 must also have an approved background check.*

Have you ever been involved in a Protective Services Investigation (PSI) that resulted in a substantiated allegation of abuse of a child or an adult against yourself? ☐ ***Yes*** ☐ ***No***

If yes, when? _____/_____/_____ ***Where?*** _____ *(Attach additional sheet if needed)*
Mo. Day Year County

I declare, under penalty of perjury, this application, to the best of my knowledge and belief, is true, correct and complete. If changes occur in this information, I will notify my State Licensing Specialist and CDDP.

_____ _____
Signature of applicant *Date*

_____ _____
Signature of co-applicant *Date*

REFERENCES: *NEW* AFH-DD PROVIDER APPLICANTS NEED TO COMPLETE THE REQUIRED REFERENCE FORM