Certified 1-2 Bed Adult Family Home Application

****ONLY COMPLETE APPLICATIONS WILL BE ACCEPTED****
Submit via website (www.cli.ngo) or email to ExpansionContracting@communitycarecw.org

Application Date:		**Date Received by Office:**	

APPLICANT INFORMATION							
Last Name:		First Name:		Middle Initial:			
Maiden Name/Also Known As:							
Date of Birth:		Social Security Number:					
Driver License Number:							
Home Phone:		Cell Phone:		Work Phone:			
Email Address:							
Address:							
City:		State:		Zip Code:			
If you have resided at this address less than five (5) years, list previous address below:							

ADULT FAMILY HOME INFORMATION	
If you are currently certified by another entity other than Community Link, Inc. please list the entity and certification date: **You will need to submit a copy of your current certificate with your application.**	
If you are not currently certified, are you applying to be certified for ☐ one (1) or ☐ two (2) adults with disabilities?	
Additional Information	
Are you applying to provide care for a specific individual?	Yes ☐ No ☐
If yes, Individual's name:	
Do you live in the home you are seeking to have certified?	Yes ☐ No ☐
Please tell us why you want to become an Adult Family Home Provider:	

CERTIFICATION INFORMATION		
As an Adult Family Home Provider, would you prefer to work with members who are (check all that apply)?		
Male ☐ Female ☐ No Preference ☐	Age:	☐ 18-25 ☐ 25-65 ☐ 65-80 ☐ 80+ ☐ No Preference
Community Link, Inc. provides services for individuals who may have one or more of the following disabilities. Please indicate which individuals you are interested in serving (check all that apply):		
☐ Intellectual Disabilities	☐ Physical Disabilities	☐ Frail Elderly ☐ No Preference
☐ Alzheimer's/Dementia	☐ Alcohol or Other Drug Addiction	☐ Mental Health

Have you or any household member even been denied licensure, certification, etc. to provide care or services?	
Yes ☐ No ☐	If yes, list date and explain:
Have you or any household member ever provided care as a certified or licensed provider in a home setting prior to this application?	
Yes ☐ No ☐	If yes, has licensure, certification, etc. ever been revoked or suspended? Yes ☐ No ☐ If yes, list date of revocation/suspension and explain:
Have you ever surrendered any type of licensure, certification, etc.?	
Yes ☐ No ☐	If yes, list date of surrender and explain:

ADDITIONAL APPLICANT INFORMATION					
Education					
High School		Highest Grade Completed		Degree	
Tech College or University		Highest Year Completed and Major		Degree	
List any current or previous licenses or certifications held by you (daycare, adult family home, CPR, First Aid, etc.):					

Current Employment	
Employer's Name:	
Employer's Address:	
Job Title:	
Employer's Telephone Number:	
Dates of Employment:	
Work Schedule:	

Former Employment: (List the last five (5) years)

Employer Name and Position	**Dates of Employment**	**Reason for Leaving**

Military Service

Branch	**Dates Served**	**Current Status**	
		Active	Discharged: List Type of Discharge
		Yes ☐ No ☐	dfd

Marital Status and Household Members

Current Marital Status:	☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced – Provide the following for prior marriage(s): Former Spouse's Full Name: Dates of Marriage: From: To:

Children (if child is married, give full name) Please use a separate piece of paper if needed

Full Name	**Age**	**Where They Currently Live**

List any individuals living in your household or who are frequent guests (persons who visit the home weekly or more often) not listed above. Use additional paper if more space is required.

Full Name	Age	Relationship to Applicant

Spouse/Partner Information (If no spouse/partner, skip to Information about Your Home section)

Last Name:		First Name:		Middle Initial:	
Maiden Name/Also Known As:					
Date of Birth:		Social Security Number:			
Driver's License Number:					
Home Phone:		Cell Phone:		Work Phone:	
Email Address:					
Address:					
City:		State:		Zip Code:	

If resided at this address less than five (5) years, list previous address below:

Spouse/Partner Education

High School		Highest Grade Completed		Degree	
Tech College or University		Highest Year Completed and Major		Degree	

List any current or previous licenses or certifications held (including daycare, adult family home, CPR, First Aid):

Spouse/Partner Current Employment

Employer's Name:	
Employer's Address:	
Job Title:	
Employer's Telephone Number:	
Dates of Employment:	
Work Schedule:	

Spouse/Partner Former Employment: (List the last five (5) years)

Employer Name and Position	Dates of Employment	Reason for Leaving

Spouse/Partner Military Service

Branch	Dates Served	Current Status	
		Active	Discharged: List Type of Discharge
		Yes ☐ No ☐	

Spouse/Partner Marital Status and Household Members

Previous marriage(s):	Yes ☐ No ☐ If yes, provide the following for prior marriage(s): Former Spouse's Full Name: Dates of Marriage: From: To:

Spouse/Partner's children not listed under Applicant information (if child is married, give full name)

Full Name	Age	Where They Currently Live

INFORMATION ABOUT YOUR HOME			
Do you own or rent your home?	Own ☐ Rent ☐	Is this home your primary residence?	Yes ☐ No ☐
If you wish to certify a home other than your primary residence, please list the address of the home to bed certified:			
Do you or any household members have a business in your home?	Yes ☐ No ☐ If yes, describe the business:		
Are there two exits from the First/Main Floor to the outside?	Yes ☐ No ☐		

Exterior Home Information (please check one):	**Interior Home Information:**
To get into the home:	To move around inside the home:
☐ Accessible (0-1 steps)	☐ Accessible (no steps to get to needed area(s) of home)
☐ Semi-accessible (2-4 steps)	☐ Semi-accessible (a couple to half flight steps to get around inside the home)
☐ Non-accessible (More than 4 steps)	☐ Non-accessible (full flight of stairs to get to needed area(s) of the home)

Does your home have well water? *AFH providers are required to have well water tested prior to certification and annually thereafter*	Yes ☐ No ☐

How did you learn about Community Link, Inc. (CLI) Adult Family Home Program? (Check all that apply)

☐ Know a Member (individual enrolled in Community Link, Inc.)
☐ Know an AFH Provider
☐ Personal experience with CLI, please specify:
☐ Employment through another agency, please specify:
☐ Media: ☐ Newspaper ☐ TV ☐ Radio ☐ Internet
☐ Other, please describe:

REFERENCES							
Please include two (2) **unrelated** people (including at least one employer) who have known you for at least a year and two (2) **relatives** that can be contacted to provide a reference for you:							
1	Name:			Relationship:			
	Address						
	City:			State:		Zip Code:	
	Telephone Number:		Email Address:				
2	Name:			Relationship:			
	Address						
	City:			State:		Zip Code:	
	Telephone Number:		Email Address:				
3	Name:			Relationship:			
	Address						
	City:			State:		Zip Code:	
	Telephone Number:		Email Address:				
4	Name:			Relationship:			
	Address						
	City:			State:		Zip Code:	
	Telephone Number:		Email Address:				

RELEASE OF INFORMATION AND APPLICATION ATTESTATION

I hereby give permission to Community Link, Inc. to contact the references provided and to obtain relevant medical, financial, criminal, and employment information needed to process the application or certification, if approved. The Authorized Representative of Community Link, Inc. is free to verify any information on the application form and contact other agencies such as Department of Health and Social Services, Human Services Departments and 51.42 Agencies.

In completing this application, I understand there is no guarantee by the agency that certification is guaranteed or a member will be placed in the home. I also understand that Community Link, Inc. is free to consult persons or agencies named herein. The information contained in this application is true and correct to the best of my knowledge. Providing false or incomplete information will result in Community Link, Inc. declining certification as an Adult Family Home.

Applicant Signature:		**Date:**	