VIABILITY
BETTER TOGETHER

# FAMILY CARE PROVIDER APPLICATION

## For Non-Family Members

NAME:_____ PHONE:_____

ADDRESS:_____
Street City State Zip

1. How did you hear about us?_____
2. Have you been an in-home-care provider with another agency?_____
3. How long have you been living at the current address?_____
4. Best time and place to be reached?_____ Phone:_____
5. Current Employer Name:_____
   Job Title:_____ Days / Hours: _____
6. Do you have a bedroom available in your home?_____
   Long Term _____ Short Term (respite) _____
   Available Times:_____
7. Do you drive? _____ Do you own a car? _____
   Is your home near public transportation?_____
8. Do you allow smoking in your home? _____
9. Please list all family members in the home and anyone else who makes regular visits:

| NAME | AGE & DOB | RELATIONSHIP | CHARACTERISTICS *(related experience)* | APPROXIMATE TIME SPENT IN HOME *(include if overnight)* |
|---|---|---|---|---|
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*** anyone who stays overnight must receive a CORI before the overnight visit**

10. Any anticipated changes in household over the next year *(people moving in or out)*?_____
11. What personal characteristics or experience do you have that might be valuable in relating to an adult who has challenges which could include medical, developmental, or emotional challenges?_____
    _____
    _____
12. List any hobbies, skills, or personal interests you would be willing to share with a participant living in your home_____
    _____

13. List any anticipated vacations, holidays, and/or religious observations:

14. Describe a typical weekday and a typical weekend:

15. What other information about yourself and your family might be helpful in getting to know you and match you with a participant?

16. What is the date of your last physical? *(a recent physical is required, and thereafter every 2 years)* _____
17. What is the date of your last TB test/screening? *(required every 2 years* _____
18. Do you have any health restrictions? _____ If yes, please explain:

19. Do you have the *(required)* physician's authorization to be an AFC provider?

20. Are you or anyone you know interested in doing any volunteering with us? *(spending time with a participant, helping with our events, helping us in the office, or other possibilities)*

## REFERENCES

*Please list full address and telephone number of three people who know you well, At least one reference from your current employer is required. Family members cannot be used as references.*

**NAME:**

ADDRESS:

BEST PHONE NUMBER TO REACH THEM:

HOW DO YOU KNOW THEM?

**NAME:**

ADDRESS:

BEST PHONE NUMBER TO REACH THEM:

HOW DO YOU KNOW THEM?

**NAME:**

ADDRESS:

BEST PHONE NUMBER TO REACH THEM:

HOW DO YOU KNOW THEM?

Signature

Date