ALLEGANY COUNTY ARC, INC.
FAMILY CARE PROGRAM
APPLICATION

Name: _____ County: _____

Address: _____ School District: _____

_____ Telephone: _____

Directions (from Wellsville to Home):

FAMILY INFORMATION

Husband: _____ Wife: _____

Date of Birth: _____ Date of Birth: _____

Employment: _____ Employment: _____

Other income (amount/source): _____ Other income (amount/source): _____

Social Security No: _____ Social Security No: _____

Health: _____ Health: _____

Education: _____ Education: _____

Drivers License No: _____ Drivers License No: _____

Do you have a car? _____ Do you have a car? _____

CHILDREN

Name	Date of Birth	Occupation	Health

Persons other than family living in home (specify relationship): _____

_____

_____

_____

PRESENT LIVING ACCOMMODATIONS

Do you own your home? _____ If yes, how long? _____
Do you rent your home? _____ Number of years at present address: _____
What/Where was your former residence? _____

TYPE OF HOME

Single: _____ Double: _____ Apartment: _____ (which floor) _____ Number of stories: _____
Number of stories: _____ Wood _____ Brick: _____ Other (describe): _____
Source of water: _____

Heating System: Furnace: _____ Type: _____
Space Heater: _____ Type: _____
Other (describe): _____

RECREATIONAL FACILITIES

In your home: _____

_____

In community: _____

_____

FIRE PROTECTION

What fire protection do you have in your home

Fire escapes: _____ Smoke detectors: _____
Fire extinguishers: _____ Other: _____

A fire/safety inspection of your home will be necessary before you can be certified. You will be required to install extinguishers and smoke detectors if you do not already have them. Do not purchase any equipment prior to the first inspection of your home.

FAMILY CARE HOME FLOOR PLAN SKETCH

INSTRUCTIONS:

1. In the spaces following, draw the floor plans for the first and second floors of your home
2. Identify the rooms
3. Show the locations of windows and exterior doors (D = Exterior Door, W = Window)
4. Write in the dimensions of all bedrooms and identify the occupants of beds
5. Show the location of smoke detectors with a star (* = Smoke Detector)
6. If basement or attic are used as a sleeping area, sketch it on a separate sheet of paper

SECOND FLOOR:

FIRST FLOOR:

(Family Care Provider Signature) **(Date)**

MEDICAL

All adult family members must supply a statement of health from their physician. Please make arrangements to have your physician's statement(s) forwarded to us.

Family Physician: _____
Address: _____
Phone Number: _____ Does he/she accept Medicaid patients? _____

Family Dentist: _____
Address: _____
Phone Number: _____ Does he/she accept Medicaid patients? _____

Pharmacy: _____
Address:
Phone Number: _____ Does this pharmacy accept Medicaid? _____

RELIGION

Name of Church: _____
Pastor/Priest Name: _____
Address: _____ Phone Numbers: _____
Are you willing to provide transportation to church services for your clients?

☐ Yes, at own church ☐ Yes, at church of client's choice ☐ No

INSURANCE

Do you have homeowner's insurance? _____
Please provide us with a copy of your cover letter with your insurance agent's name listed

Your present policy may be affected by accepting clients into your home. Your coverage should cover potential loss of both provider and client property. Please check with your insurance agent.

PROGRAM INTEREST

Why are you applying to our Program? _____

Does your entire family share an interest in the Program? _____

What type of client (age, sex, physical handicap) would you prefer? _____

Have you had any previous experience with mentally retarded individuals? _____ If yes, please describe: _____

Where did you hear of our program? _____

_____

What community activities do you participate in? _____

_____

Do you have any special talents or interests that you could share with our clients? _____

_____

Have you ever applied for Family Care Home status at any other agency? _____ If yes, when and what agencies? _____

_____

Are you still involved with this agency? ____ If no, when did you terminate and your reason for termination?

_____

_____ May we use this agency for a reference? _____

To your knowledge, are there any other Family Care homes located in your area? _____

TRANSPORTATION

Will you provide transportation for resident for emergencies, clinics, interviews, etc., to the Allegany County ARC, or in the community as the need ___ Yes _____ No

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include military service assignment, volunteer activities and child care. In the margin, please indicate any other **NAMES** you were known by at each place of employment.

LENGTH OF EMPLOYMENT: From: Mo. _____ Yr. _____ To: Mo. _____ Yr. _____	**EMPLOYER:** _____ **ADDRESS:** _____ **PHONE:** _____	
RATE OF PAY: Beginning _____ Final _____	**JOB TITLE:**	**NAME/TITLE OF SUPERVISOR**
WORK PERFORMED:	**REASON FOR LEAVING:**	

LENGTH OF EMPLOYMENT: From: Mo. ______ Yr. ______ To: Mo. ______ Yr. ______	**EMPLOYER:** ______ **ADDRESS:** ______ **PHONE:** ______	
RATE OF PAY: Beginning ______ Final ______	**JOB TITLE:**	**NAME/TITLE OF SUPERVISOR**
WORK PERFORMED:	**REASON FOR LEAVING:**	

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WORK PERFORMED:	**REASON FOR LEAVING:**	

Do you have any other experience as an employee, volunteer, or certified provider with OMRDD; any other State agency; or other provider of human services **not** listed under employment? Please list here (use separate sheet of paper, if necessary):

____

____

____

____

EDUCATION

Circle highest grade completed:

1, 2, 3, 4, 5, 6, 7, 8 Elementary	9, 10, 11, 12 High School	1, 2, 3, 4, 5, 6 College	1, 2 Trade/Business

School	Name	City/State	Major Course	Degree
High School				
College (1)				
College (2)				
Trade/Business				

REFERENCES

Give name, complete address and telephone number of three references who are not related to you who can attest to your character, reputation, and personal qualifications.

Name	Complete Address	Phone Number

State any additional information you feel may be helpful to us in considering your application; include licenses or certifications or relevant education or training regarding care of or service to developmentally disabled. (use separate sheet of paper, if necessary):

APPLICANT'S STATEMENT

This application is not complete until you read and sign the following two statements

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application, as may be necessary in arriving at a decision. I understand that family care providers contracted by this Agency are required to take and pass a physical examination and a PPD test as a condition of employment. I understand that this application is not, and is not intended to be, a contract of employment.

In the event of employment, I understand that false or misleading information given in my application or resume, or interview(s) would be grounds for immediate discharge. I understand, also, that I am required to abide by all rules and regulations of the Family Care Program.

(Signature of Applicant) (Date)

APPLICANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

In connection with my application as Family Care provider for Allegany County ARC, authorize all persons, corporations, companies, educational institutions, law enforcement agencies, present and former employers and the military services to disclose and release records they may have about me to Allegany County ARC whether the information be of a public, private or confidential nature; and, I release them from liability and responsibility from doing so.

I understand that any information obtained by a personal history background investigation which is developed directly or indirectly, in whole or in part, upon this release authorization may be considered in determining my suitability for Family Care Provider for Allegany County ARC.

This authorization, in original or copy form, shall be valid for this and any future information, reports or updates that may be requested.

(Applicant's Name - please print) Applicant's Signature