

Family Care

SUBSTITUTE PROVIDER APPLICATION Family Care Home:

APPLICANT INFORMATION

Applicant Name: DOB:

Address:

 (Street) (city/State) (Zip)

Phone: Social Security Number:

Education (list highest grade completed): Marital Status:

Relationship (if any) to Family Care Provider:

If respite is to occur in the respite provider's home, please list the name and age of each person living in the home and relationship to applicant:

Name	Age	Relationship
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EXPERIENCE (give details):

Detail experience with individuals who are developmentally disabled: How many years:

I qualify as a respite worker because (include any experience providing direct care services):

EMPLOYMENT HISTORY :

Date: Occupation:

Employer Name, Address and Phone:

Date: Occupation:

Employer Name, Address and Phone: