

Adult Foster Home (AFH-DD) License Application

Section 1 — Instructions

New Applicants: Complete the License Application and other required licensing materials; attach a non-refundable fee of \$20.00 per bed, (*check or Money Order made out to DHS*) and mail all items to the County CDDP Office.

Renewals: Complete the License Application, follow the instructions in your renewal packet and mail it to your local CDDP Office unless you have been instructed to mail directly to: DD Licensing Unit, P.O. Box 14530, Salem, OR 97309

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: _____

Site address: _____ Cell: _____

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 (*If renting/leasing send 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 (*Include annual proof of testing.*) Wheelchair ramp

Swimming pool Wood stove or fireplace 2-story home

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, all family members, children, grandchildren, etc., and staff who live in the home. Must include Social Security number and date of birth for all, use additional sheet if necessary.

Full name	Relationship	Requires care	SSN	Date of birth
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Are they vaccinated for rabies? Yes No (*You must submit rabies vaccination proof annually.*)

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, you must have a resident manager live in the AFH-DD.

Section 3 — Provider information

Education: Please list school name, location, last grade and the year completed.

School name	City/State	Last grade completed	Year

Employment: Describe previous paid, volunteer or family experience or training in working with individuals with development disabilities. (*Use additional sheet if necessary.*)

Name of employer	Address	Dates employed	Reason for leaving

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

(If yes, please list where the position is held, days and hours worked per week.)

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:

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

Address	County	Phone number of licensor/contact

Business information:

A. Are you currently operating your AFH-DD under a business license? Yes No

B. What is the name of your business? (*Came name as on your Oregon Business License and on your Federal tax information.*)

Tax ID number: _____ **If you have a Federal IRS Tax ID number you must send a copy of your tax ID number award letter from the IRS.**

C. Legal status of your business: Individual Partnership Corporation
 LLC Non-profit limited partnership Other: _____

- D. For “C” above, list the individuals who:
1. Have a controlling (*majority*) interest in the business; OR
 2. Are an officer or partner of the business; AND
 3. Indicated by who lives in the home (*see *definition below*).

Print name	Date of birth	Interest in business	Live in AFH-DD	
Example: Joe Green	5/15/1955	Partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

***Definition:** To live in the home means that this is your full-time residence you customarily and regularly conduct your activities of daily living (e.g., sleeping, eating, bathing and recreating).

