

Adult Foster Home Initial License Application Instructions



When completing this application:

- Type or print clearly using blue or black ink.
- Answer each question or check the N/A box to indicate not applicable.
- Section 1 requests your tax identification number (TIN), employer identification number (EIN) or social security number (SSN). Your TIN, EIN or SSN will be used to verify you are not listed on either the U.S. Office of Inspector General (OIG) or the U.S. General Services Administration's System for Award Management (SAM) Exclusion Lists. Disclosure of your SSN is optional for purposes of this application. However, choosing not to disclose your SSN number may potentially impede the local licensing authority's ability to verify your qualifications as required in OAR 411-050-0625.
- Provide all of the supplemental information requested, including the non-refundable fee.
- Sign and date your completed application.
- Make a copy for your records and submit the completed original application materials to the local licensing authority.
- Submit all applications together, such as for a co-licensee, resident manager, floating resident manager and shift caregivers, as applicable.
- Call the local licensing authority if you have questions about completing this form.

Application Processing Timelines

Submit all of the requested information with your application. Once your application and fee are received by the local licensing authority, your application will be processed to determine you meet the minimum standards as required by OAR 411-050-0600 through 411-050-0690. The local licensing authority will check your references, verify your work experience and confirm you have the necessary qualifications and you have obtained the required training.

Help to avoid unnecessary delays by submitting all of the required application materials, including the fee, at one time. Your application will become void if it remains incomplete for more than 60 days, and unless you withdraw your application, DHS may deny your application for a license. You may withdraw your application at any time by sending a written request to the local licensing authority.

The final steps in the initial application process include a personal interview with you and a home inspection to confirm your home meets the minimum standards as required by the OARs. If you have any questions about the licensing process or the status of your application, contact your licenser at the local licensing authority.

Adult Foster Home (AFH) Initial License Application



To be completed by licensee applicant

1 – General information

A. Applicant name:

B. Phone numbers:

AFH landline number:	Applicant's home phone:
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AFH fax number:	Applicant's cell number:
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C. Adult Foster Home address (*street/box/city/state/ZIP code*):

D. Applicant's mailing address (*if different*):

E. AFH's business name:

F. AFH business email address:

G. Capacity:

What is the maximum number of AFH residents you want to provide care for?

Number of day care persons:	Number of room and board tenants:
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Number of relatives needing care and services (*including children*):

H. Class: Class 1 Class 2 Class 3

Note: The classification of your AFH license will be determined according to OAR 411-050-0630.

2 – Applicant information

A. Date of birth (*mm/dd/yyyy*):

Applicant's SSN ; or TIN ; or EIN (*see instructions*)

B. If your application for licensure is successful, will this AFH be your primary residence?
 Yes No

If no, provide your primary street address: Check here if same address as Section 1-D.

C. Have you ever been employed as a DHS homecare worker? Yes No

Are you now, or have you ever been licensed or certified as a:

Provider Resident manager or Shift caregiver in an AFH?

D. If yes, what county? (If outside of Oregon, indicate where.)

Identify the agency or agencies that issued the AFH license(s) or other certificate(s):

DD (*Developmental Disabilities*)

APD (*Aging and People with Disabilities, formerly Seniors and People with Disabilities*)

DHS (*Child Welfare, Self-Sufficiency, Child Care*)

County Ordinance (*Multnomah*)

OHA (*Oregon Health Authority*) Mental Health AFH

Veterans Administration

Other states (*identify the licensing agencies*):

E. **Emergency contact(s):** Provide current contact information for at least one emergency contact.

Name	Phone number	Relationship to applicant

F. **Applicant history:**

1. Have you ever had a license or certificate for a foster home or other long-term care facility denied, suspended or revoked? Yes No

If yes, by whom?

Date:

2. Have you ever had a substantiated finding of abuse or neglect? Yes No

If yes, by whom?

Date:

3. Have you ever voluntarily surrendered a license while under investigation or administrative sanction? Yes, on date: No (*describe*):

4. Have you ever been placed on the Office of Inspector General's (OIG) exclusion list or the General Services Administration's (GSA) exclusion list? Yes No

G. Education:			
School	City (Country if outside the USA)	Degree or number of years	Year

H. Special qualifications (if valid in Oregon):

Registered nurse License number: _____
 Registered practical nurse License number: _____
 Registered medical assistant License number: _____
 Registered nursing assistant License number: _____
 American sign language Certification number: _____
 Fluent in language(s) other than English
List languages: _____
 Other:
License or certificate number as applicable: _____

I. List all occupants in your home:
Include all persons who live in your adult foster home. Examples: children, spouses, live-in caregivers, room and board occupant. (Attach additional pages if necessary.)

AFH occupant names:	Relationship to applicant:	Date of birth:

J. Work history:

List your caregiving experience to demonstrate your qualifications. (*Attach a separate sheet of paper if you would like to include additional work history.*)

Job one:

Contact person:

Name of business:

Phone:

Mailing address (*street/box/city/state/ZIP code*):

Your job title:

Start date (*month/year*):End date (*month/year*):

Hours worked per week:

Did you provide care to persons who were dependent in four (4) or more activities of daily living (ADLs)?

 Yes No

Describe your job duties:

Job two:

Contact person:

Name of business:

Phone:

Mailing address (*street/box/city/state/ZIP code*):

Your job title:

Start date (*month/year*):End date (*month/year*):

Hours worked per week:

Did you provide care to persons who were dependent in four (4) or more activities of daily living (ADLs)?

 Yes No

Describe your job duties:

Job three:	
Contact person:	
Name of business:	Phone:
Mailing address (<i>street/box/city/state/ZIP code</i>):	
Your job title:	
Start date (<i>month/year</i>):	End date (<i>month/year</i>):
Hours worked per week:	
Did you provide care to persons who were dependent in four (4) or more activities of daily living (ADLs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your job duties:	
Job four:	
Contact person:	
Name of business:	Phone:
Mailing address (<i>street/box/city/state/ZIP code</i>):	
Your job title:	
Start date (<i>month/year</i>):	End date (<i>month/year</i>):
Hours worked per week:	
Did you provide care to persons who were dependent in four (4) or more activities of daily living (ADLs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe your job duties:	

K. General references:

Provide three references who are **not** related to you. Current or potential AFH licensees and coworkers of the applicant are not eligible to be a general reference.

1) Name:

Phone number:

Mailing address (*street/box/city/state/ZIP code*):

2) Name:

Phone number:

Mailing address (*street/box/city/state/ZIP code*):

3) Name:

Phone number:

Mailing address (*street/box/city/state/ZIP code*):**L. Licensed health care professional references:**

*If you are requesting to operate or work in a Class 3 AFH, identify two licensed health care professionals who have **direct knowledge** of your ability and past experience as a caregiver.*

Note: "Licensed health care professional," as defined in OAR 411-050-0602, means a person who possesses a professional medical license in Oregon such as a medical doctor, osteopathic physician, physician assistant, nurse practitioner, registered nurse, licensed practical nurse, physical therapist, occupational therapist or respiratory therapist.

Do not include the name of your personal health care provider unless he or she has direct knowledge of your experience as a caregiver.

1) Name and title of medical professional:

Phone number:

Mailing address (*street/box/city/state/ZIP code*):

2) Name and title of medical professional:	Phone number:
Mailing address (<i>street/box/city/state/ZIP code</i>):	

3 – Application requirements checklist:

Include copies of the following documents with your completed application, SDS 0448. Check the corresponding boxes to indicate completion or check the box marked N/A if it does not apply to you.

- Application fee:** Enclose a check for \$20.00 per resident bed (*maximum \$100.00*) Do not enclose cash.
- Co-applicant (*if applicable*):** Enclose co-applicant's completed SDS 0448 application and supplemental materials. N/A
- Resident manager and/or floating resident manager (*if applicable*):** Enclose completed [SDS 0448B](#) and supplemental materials. N/A
- Shift caregivers (*if applicable*):** Enclose completed [SDS 0448B](#) and supplemental materials for each shift caregiver. N/A
NOTE: Substitute caregivers who are routinely left in charge of the AFH for any period that exceeds 48 hours must meet the requirements of a resident manager.
- Physician or nurse practitioner's statement:** Submit the completed, signed and dated original of DHS's current Health History and Physician/Nurse Practitioner's Statement ([SDS 0903](#)).
- Background check verification:** Enclose a completed and current Background Check Request form ([MSC 0301QED](#)) for all subject individuals, including but not limited to: persons 16 years of age and older who are occupants on the AFH premises, all caregivers and caregiver applicants (*such as: licensee, resident manager, floating resident manager, shift caregiver, substitute caregiver, trainee and other employees according to OAR 411-050-0620*). See the definition of "subject individual" in OAR 411-050-0602.
Submit new background check requests for any currently approved background check that will expire within 60 days of the date this application is received by the local licensing authority.
- Special qualifications:** Attach proof of any credentials, as identified on page 3 (H). N/A
- Orientation:** Attach proof of attending an approved adult foster home orientation provided by the local licensing office.
- Ensuring Quality Care course:** Submit documentation of successful completion of DHS's Ensuring Quality Care course and examination according to DHS's current EQC Student Policies.

- Financial information:** Submit verification of having at least two months of operating expenses readily available according to OAR 411-050-0610 using:
- DHS's current AFH Financial Information sheet ([SDS 0448A](#)); and
 - DHS's current AFH Verification of Financial Resources ([SDS 0448F](#)); or
 - Applicant's financial information is summarized on the letterhead of your financial institution (see OAR 411-050-0610); or
 - Be prepared to demonstrate you have sufficient cash on hand, when combined with any other liquid resources, equals at least two months of operating expenses.

- Medicaid provider enrollment:** Submit a completed Medicaid Provider Enrollment Agreement ([SDS 0738](#)). This is required only if you intend to provide care for residents eligible for Medicaid.
- N/A

- Residential agreements:** Provide copies of your residential agreements for private-pay residents and for recipients of Medicaid. Refer to OAR 411-050-0615(2) for the specific requirements.

- Ownership of AFH:** Attach proof that you are buying or own the home to be licensed, if applicable. N/A

- Lease or rental agreement:** Attach a copy of the completed lease or rental agreement for residential use. Include the landlord's name and address, verification that the rent is a flat rate, signatures and date(s) signed by the landlord and the applicant. N/A

- Multiple AFHs:** If you are requesting to operate more than one AFH, attach a written plan that describes the following: N/A
- How you will manage the additional administrative responsibilities; and
 - How you will maintain sufficient and qualified staff for your AFHs.

- Written plan of operation ([SDS 0351](#)):** Provide a written statement that includes the following information at a minimum:
- Describes how substitute caregivers and any other staff will be used in the AFH.
 - Identifies a qualified back-up licensed provider or approved resident manager, who has been approved by DHS or area agency on aging and has agreed to be your back-up caregiver.
 - Describes your staffing plan for any primary caregiver absences.

- AFH back-up agreement:** Attach a completed AFH Back-Up Agreement ([SDS 0350](#)).
Required annually.

- Floor plan:** Provide a current and accurate floor plan for all levels of your AFH that includes the following information:
- The size of rooms.
 - Identifies which bedrooms are to be used by residents, the licensee, other caregivers, any room and board tenants and day care individuals if applicable.
 - Location of any wheelchair ramps.
 - Indicates the location of all smoke alarms, carbon monoxide alarms and fire extinguishers.
 - Identifies the planned evacuation routes and the initial and final points of safety.
 - Any designated smoking areas in or on the AFH premises.

4 – Certification and signature

The rules referenced below are available at www.dhs.state.or.us/policy/spd/numeric.htm.

I certify that I have read the current Oregon Administrative Rules, OAR 411-050-0600 through 411-050-0690, Licensure of Adult Foster Homes for Adults who are Older or Adults with Physical Disabilities.

I certify that I have read the current OAR 411-004-0000 through 411-004-0040, Home and Community-Based Services and Settings and Person-Centered Service Planning.

I certify that I have read the current OAR 411-020-0002, Definitions, Adult Protective Services - General.

I understand and agree that:

- My application is not complete until all required items have been submitted.
- If my application is incomplete, it becomes void after 60 calendar days from the date it is received by the local licensing authority and DHS may deny my application unless I withdraw it.
- The fee is non-refundable.
- Failure to provide accurate information may result in the denial of my application.
- DHS or area agency on aging will use the information I provide to verify my qualifications for an adult foster home license.
- If my application is denied, I will have the right to a contested case hearing.

I declare, under penalties of perjury under the laws of the State of Oregon, and by my signature, that the information provided in this application and all supplemental materials are true and complete.

Applicant's printed name:

Signature of applicant:

Date: