LICENSE RENEWAL APPLICATION
Adult Care Home Program
Multnomah County

AGING AND DISABILITY SERVICES 421 SW Oak St, Suite 650 PORTLAND, OREGON 97204-1817
PH: (503) 988-3000
FX: (503) 988-5722
Email: advsd.adult.carehomeprogram@multco.us

ACHP USE ONLY:

APPLICATION Checklist

Return completed application by: _____

Operator Name:_____

License number: _____

DO NOT REMOVE THIS PAGE FROM THE APPLICATION

DIRECTIONS: It is critical that we receive your renewal by the above date in order to ensure that there is not a lapse in your license. Before mailing your renewal, please ensure you have completed all items on the checklist below. Incomplete renewal applications will be returned.

** Room & Board Operators can skip these items.

- ☐ Sign and date the application.
- ☐ Pay the required fees from the Fee Determination Form.
- ☐ Submit a Background Check Request (BCR) form with a copy of the government issued photo ID for all persons16 or older who live, work or make use of the facilities on a frequent basis.
  NOTE: NEW or EXPIRED applicants must bring their BCR form and photo ID in person. Please remember that the ACHP does not conduct background checks on residents or residents' visitors.
- ☐ ** Sign and date a Medicaid Provider Enrollment Agreement, if appropriate.
- ☐ ** List all Continuing Education (CE) classes completed this year. Please attach copies of certificates.
  NOTE: There are no CE requirements for Limited or Room & Board homes.
- ☐ Complete Staffing Plan – A Typical Week.
- ☐ ** Attach a completed Physician's Report Form, signed and dated by a physician EVERY TWO YEARS.
- ☐ ** Current First Aid Training & CPR Training – Attach copies of the certificates for operator and all caregivers in the home. Be prepared to provide documentation during licenser's visit that caregivers have met all appropriate caregiver requirements.
- ☐ Update and submit a signed Back-Up Operator Agreement form. You are required to have a current licensed operator or approved resident manager who has agreed to manage your home in the event of an emergency.023-090-405(k)

IF ANY PART OF THIS APPLICATION IS NOT COMPLETED CORRECTLY, ALL FORMS WILL BE RETURNED TO YOU. ALWAYS MAKE COPIES OF YOUR COMPLETED APPLICATION **FOR YOUR RECORDS**.

If the Operator does not submit a complete renewal application packet before the license expiration date, the ACHP shall treat the home as an unlicensed home (Refer to MCAR 023-040-620.)

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Operator Information

DIRECTIONS: Read carefully and complete using a black or blue pen or type. Return to the above address with appropriate license application fees. INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

1. Last Name:	7. Operator's Physical Street Address:
2. First Name:	City: State: Zip:
3. Middle Name:	8. Operator's Mailing Address:
4. Other names used (last, first, middle):	City: State: Zip:
5 Home phone: ( ) -	9. Email:
6. Cell phone: ( ) -	* *

Are you currently or have you previously been licensed / certified in another county or state? Yes ☐ No ☐

If you have been licensed / certified for any type of care facility including child welfare, please list the addresses and license numbers.

Address:	City:	State:	Zip:	Facility Type/License #
Address:	City:	State:	Zip:	Facility Type/License #
Address:	City:	State:	Zip:	Facility Type/License #

Have you ever had a license denied, suspended, or revoked? If YES, by WHOM? _____ Reason: _____	Yes ☐ No ☐
Have you ever been found to have committed abuse? If YES, Explain: _____ _____ _____	Yes ☐ No ☐

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In the last 12 month have you had any unsatisfied **judgments**, **liens**, or pending **lawsuits** in which a claim for money or property is made against you? If YES, Explain: _____	Yes ☐ No ☐
In the past 12 months have you ever filed **bankruptcy** or been **delinquent** (behind) with your property taxes, utilities or household bills? If YES, Explain: _____	Yes ☐ No ☐

Special Qualifications – Check all that apply, and provide proof of current certification (attach a copy, if applicable)

- ☐ Registered Nurse: State and License: _____
- ☐ Licensed Practical Nurse: State and License: _____
- ☐ Certified Nurses Aid: Certificate: _____
- ☐ Certified Med-Aid: Certificate: _____
- ☐ Sign Language
- ☐ Other Language(s) Spoken: _____
- ☐ Other: _____

Required Training

- ☐ First Aid Training – Expiration Date: ____/_____/_____
- ☐ CPR Training – Expiration Date: ____/_____/_____

NOTE: Attach copies of the certificates for operator.

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Professional Development Training Received Last 12 months – Attach copies of all CE certificates.

Title of Training	Date	# of Hours
NOTE: 12 hours required annually for Class I; 14 hours required for Class II; 16 hours required for Class III licenses. (*First Aid and CPR do NOT count toward required hours*.)	TOTAL HOURS	

Availability

Do you currently attend school or have a job or business inside or outside of the adult care home? If yes, where: _____ (Company Name / Name of School) (Address) (Telephone) What is your schedule for school and/or work? Include the number of hours you are engaged in these extra activities each week. Explain: _____	Yes ☐ No ☐

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Adult Care Home Information

Facility Location & Contact Information

Physical Street Address:		
City:	State:	Zip:
Facility Phone: ( ) -	Other Phone: ( ) -	

Mailing Address (if different from physical address):		
City:	State:	Zip:
Email:		

Name of Operator:	Phone:	Do you live on-site?	Yes ☐ No ☐
Name of Resident Manager (if any):	Phone:	Is there a Resident Manager?	Yes ☐ No ☐
List anyone else who lives or works in the home? If YES, please list each individual below:		Are any others in the Home?	Yes ☐ No ☐

Name:	Date of Birth:	Relationship to Operator/Manager:	LIVE	WORK	Background Check Completed?
			☐	☐	Yes ☐ No ☐
			☐	☐	Yes ☐ No ☐
			☐	☐	Yes ☐ No ☐
			☐	☐	Yes ☐ No ☐
			☐	☐	Yes ☐ No ☐

Number of people you are currently caring for?

ACH Residents	Room & Board	Day Care	Respite	Relatives	Other	TOTAL

Physical Characteristics

Have you made any additions, done any remodeling, made electrical changes etc...? Yes ☐ No ☐

Please describe and attach a copy of permit(s).

_____

_____

_____

_____

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Ownership of the Property

Do you **rent or lease the facility** to be used as an Adult Care Home? If YES, please provide contact info for the property Owner: Name: _____ Phone: _____ Address: _____	Yes ☐ No ☐
If you own the property, is there any other: Owner(s), Partner(s) Corporate Officer(s) responsible for this ACH beside yourself? (Is there any other person or entity with any legal or financial interest in and with the right or power of control over the operations or physical structure of the Adult Care Home?) If YES, WHO? _____ _____	Yes ☐ No ☐

Declaration

Operators, resident manager and caregivers shall have good physical and mental health, good judgment, good personal character (including honesty) and the demonstrated ability to follow both verbal and written instructions. They shall also possess the ability as determined necessary by the ACHP to provide 24 hour supervision for adults who are elderly persons or persons with disabilities. Failure to meet the above standard may lead to sanctions by the ACHP, including but not limited to, fines, revocation, denial of a license, and the placement of conditions onto an existing license. *MCAR 023-070 – 140.*

I declare under penalties of perjury that I have examined this application and to the best of my knowledge and belief it is true, correct, and complete. I hereby authorize the department to conduct an investigation of my background. If granted a license I understand that I am required by law to comply with all applicable laws and rules, to comply with the standards for adult care home, and to comply with the resident's bill of rights. I agree to cooperate with the department in all future inspections, interviews and other investigations conducted in order to approve a license and to monitor continuing compliance in my Adult Care Home.

Signature	Print Name	Date

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STAFFING PLAN

Operator: _____ Resident Manager (if applicable): _____

ACH Address: _____ City: _____ State: OR Zip _____ Phone: _____

Who is the live in care provider? ☐ Operator ☐ Resident Manager ☐ Shift Resident Manager

List all caregivers including substitute caregivers, resident managers and operators and the scheduled hours in a typical work week.

Caregiver Name	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Example: Marcia Brady	8am – 2pm	X	X	X	7am – 3pm	7am – 3pm	8am – 2pm

If operator works outside of the ACH, provide outside work schedule (days / hours): (Example: Mon thru Thurs 10am - 7pm)

_____

Name of back-up licensed operator or approved resident manager:_____

Address: _____ City:_____ State:_____ Phone:_____

Oriented to home? ☐ Yes ☐ No

Operator signature: _____ Date:_____

All Caregivers listed on this form have had a current background record check. _____ **Date:** _____
Operator Signature

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ADULT CARE HOME BACK-UP OPERATOR AGREEMENT

All adult care home Operators in Multnomah County are required to provide the name of another currently licensed Operator or approved Resident Manager who has agreed to oversee and monitor the adult care home in the event of an emergency. (MCAR 023-040-320(m), and MCAR 023-090-405(k))

Adult Care Home

License #: _____

Operator/Applicant Name: _____

Adult Care Home Address: _____

Adult Care Home Phone: _____

The individual named below has agreed to respond in person in the event of an emergency where the licensed Operator is incapacitated or absent from the home. We the undersigned attest that the individual named below has the ability to temporarily oversee and monitor this home and has been:

- ☐ Introduced to all residents and staff
- ☐ Oriented to resident care plans and location of resident records
- ☐ Delegated for all currently required skilled nursing tasks
- ☐ Oriented to resident medications and means to access locked medication storage
- ☐ Oriented to the Emergency Preparedness Plan for the home
- ☐ Has a background check approval from the Adult Care Home Program

Back-Up Operator or Resident Manager

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Signature (*Back-up Operator or Resident Manager*): _____ Date: _____

Signature (*Operator/Applicant*): _____ Date: _____

This agreement shall remain in effect through the current expiration date of the adult care home license unless revoked in writing by either party or the ACHP.

FOR ACHP USE ONLY

Approved by:

Signature (*Licenser*): _____ Date: _____

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Personal Emergency Contact -- List anyone you want contacted in case of emergency.

Name:	
Address:	
City/State/Zip:	
Home phone: ( ) -	Cell phone: ( ) -

Personal Emergency Contact -- List anyone you want contacted in case of emergency.

Name:	
Address:	
City/State/Zip	
Home phone: ( ) -	Cell phone: ( ) -

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FEE DETERMINATION FORM

1. **List all individuals 16 years or older that will be working, living or visiting the adult care home on a frequent basis.**
2. **If a current background check approval letter exists, list the expiration date under BCR expiration date *(no fees),***
3. **All new individuals need to appear in-person to complete the background check.**

Number of Beds applying for:_____X **$60.00 per bed** = $_____

OPERATOR NAME $15 Background check fee, if needed	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$

RESIDENT MANAGER NAME **$**25 Application (all applications) $15 Background check fee, if needed	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$

CAREGIVERS $10 Application (all applications) $15 Background Check Fee (if needed)	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$
			$
			$

FAMILY MEMBERS NAME NOT PROVIDING CARE $15 PER PERSON (PAY FOR 1ST THREE ONLY)	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$
			$
			$

FREQUENT OCCUPANT NAME ($15 Per Person)	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$
			$
			$

HOUSE KEEPERS GROUNDSKEEPERS NAME $15 PER PERSON	**BCR EXPIRATION DATE**	**COPY OF PHOTO ID REQUIRED**	**FEES SUBMITTED**
			$
			$

TOTAL AMOUNT ENCLOSED: $_____

CAREGIVER APPLICATION

Adult Care Home Program
Aging, Disability & Veterans Services Division

☐ **Caregiver Application ($10 Fee Included)** ☐ **New** ☐ **Renewal**

☐ **Attach Background Check Approval or complete the ACHP Background Check Application**

APPLICANT INFORMATION: *Please attach a copy of your current government-issued photo ID.*

1. Last Name	6. Government ID Type *(Driver's License, Passport, etc.)*
2. First Name	7. Government ID Number
3. Middle Name	8. Government ID State or Country of Issue
4. Other Names Used *(last, middle, first)*	9. Social Security Number *(optional)*
5. Date of Birth	10. Gender ☐Male ☐Female

11. Please choose any/all of the following to describe your race/ethnicity. This information is voluntary and will not be used in any way to determine your eligibility.

☐ African & African Immigrant ☐ Middle Eastern ☐ White
☐ Asian ☐ Native American or Alaska Native ☐ Slavic
☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ Latino/Hispanic
☐ Decline to answer

CONTACT INFORMATION: *Do not use the Operator's address unless you will live in the Adult Care Home.*

12. Home Phone	Cell Phone		13. Email Address		
14. Physical Street Address & Apt. Unit			15. Mailing Address *(if different from physical address)*		
City	State	Zip Code	City	State	Zip Code

EMPLOYMENT INFORMATION:

16. Check the box for the population you intend to provide care for:
☐ APD (Aging & People with Disablities) ☐ DD (Developmental Disabilities) ☐ AMH (Addictions & Mental Health)

17. Which Operator do you plan to work for and how many hours do you plan to work each week?

Operator's Name: _____ License #: _____ Hours per week: _____
Operator's Name: _____ License #: _____ Hours per week: _____
Operator's Name: _____ License #: _____ Hours per week: _____

18. Will you be providing transportation services to residents in the adult care home? ☐Yes ☐No
If yes, please attach a copy of your valid driver's license.

APPLICANT HISTORY:

19. Have you ever had a substantiated finding of abuse or neglect? ☐Yes ☐No
If yes, by which agency? Date:

20. Have you ever had a license, certification or approval for an adult care home, child foster home, personal support worker, home care worker, or other long-term care facility denied, suspended or revoked? ☐Yes ☐No
If yes, by which agency? Date:

21. 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

TRAINING AND QUALIFICATIONS:

22. Are you currently, or have you ever been, licensed or certified as a Caregiver, Resident manager or Operator in an Adult Care Home ? If yes, where? Date: *Attach additional pages if necessary*.	☐ Yes ☐ No
23. Have you ever had a CNA license or other health professional license? Professional License / State: / License Number ☐ Certified Nursing Assistant _____ _____ ☐ Certified Medical Assistant _____ _____ ☐ Licensed Practical Nurse _____ _____ ☐ Registered Nurse _____ _____ ☐ Other: _____ _____	☐ Yes ☐ No

24. Education & Training Requirements:
Please attach copies of certificates or other verification.

New Caregivers:	Renewing Caregivers:	Caregivers who work alone:
☐ DD: Basic Training	☐ DD: 12 hours of CEU's	☐ First Aid
☐ DD: ACHP Qualifying Test	*Note: All CEU's must be on the list of State-approved courses or approved through Region 1*	☐ CPR
☐ DD 2B Homes: Current OIS	☐ AMH: Caregiver Workbook	
	☐ APD: Caregiver Workbook	

APPLICANT ACKNOWLEDGEMENTS:

25. I understand that I must immediately notify the Operator and the Adult Care Home Program if my state background check (final fitness determination) is revoked for any reason.	***Initials:*** _____
26. I understand that Operators, Resident Managers and Caregivers with reasonable cause to believe that abuse, neglect or exploitation has taken place in an adult care home shall immediately make a report to Adult Protective Services or a local law enforcement agency. MCAR 023-120-125.	***Initials:*** _____
27. Operators, Resident Managers and Caregivers shall have good physical and mental health, good judgment, good personal character (including honesty) and the demonstrated ability to follow both verbal and written instructions. They shall also possess the ability as determined necessary by the ACHP to provide 24 hour supervision for older adults or persons with disabilities who need assistance with activities of daily living. I understand that failure to meet the above standard may lead to sanctions by ACHP, including, but not limited to, fines, revocation, denial of a license, and placement of conditions on an existing license. MCAR 023-070-140.	***Initials:*** _____
28. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the position.	***Initials:*** _____
29. I understand that my application will be denied if I fail to complete the application within 60 days. All qualifications must be met before the application can be approved. Qualifications are listed in Question #24, above.	***Initials:*** _____

Signature:_____ Date: _____

Multnomah County Adult Care Home Program, 421 SW Oak St, Suite 650, Portland OR 97204
Phone: 503-988-3000 Fax: 503-988-5722 Email: advsd.adult.carehomeprogram@multco.us
Last Updated October 31, 2016

BACKGROUND CHECK REQUEST

Adult Care Home Program
Aging, Disability & Veterans Services Division

☐ **Background Check Request ($15.00 included)** ☐ **New (must be seen in person)**

☐ **Background Check Approval Verification Attached (no fee)** ☐ **Renewal**

APPLICANT INFORMATION: *Please attach a copy of your current government-issued photo ID.*

1. Last Name	6. Government ID Type *(Driver's License, Passport, etc.)*
2. First Name	7. Government ID Number
3. Middle Name	8. Government ID State or Country of Issue
4. Other Names Used *(last, middle, first)*	9. Social Security Number *(optional; used to confirmed identity during criminal records check process)*
5. Date of Birth	10. Gender ☐Male ☐Female

CONTACT INFORMATION: *Do not use the Operator's address unless you will live in the Adult Care Home.*

11. Home Phone	12. Cell Phone		13. Email Address		
14. Physical Street Address & Apt. Unit			15. Mailing Address *(if different from physical address)*		
City	State	Zip Code	City	State	Zip Code

ROLE AND POPULATION

16. Check one box for your role. *Note: a separate background check is required for each role.*
Care Provider (ACHP Application required): ☐ Caregiver ☐ Resident Manager ☐ Operator
Noncaregiver (background check only): ☐ Household Member ☐ Occupant
☐ Volunteer ☐ Housekeeper ☐ Property Maintenance ☐ Other:

17. Check the box for the population you intend to provide care for or have contact with:
☐ APD (Aging & People with Disablities) ☐ DD (Developmental Disabilities) ☐ AMH (Addictions & Mental Health)

18. Will you have direct contact with any of the following? ☐ Adults ☐ Seniors (age 65 or older)
☐ Confidential information ☐ Secure Facilities ☐ Finances or financial records ☐ Information Technology Systems

19. Will you be providing transportation services to residents in the adult care home? *If yes, please attach a copy of your valid driver's license.*	☐Yes ☐No

APPROVED BACKGROUND CHECK OR LONG-TERM CARE REGISTRY

20. Do you have a current approved background check (final fitness determination) from the state Background Check Unit for this role and this population, or are you on the Long-Term Care Registry (LTCR)?	☐Yes ☐No
• *If yes, attach a copy of the approval letter from the state Background Check Unit or Long-Term Care Registry. List approval dates and complete #26 through #28.* • *If no, complete #21 (New Background Check Request) through #28 on next page.*	LTCR Expiration Date:

21. NEW BACKGROUND CHECK REQUEST ($15 fee required)
Only complete this section if you do not have a current approved background check (final fitness determination), or if you are not on Long-Term Care Registry, for this role and population.

22. Are you requesting preliminary approval pending final background check approval?	☐Yes ☐No
23. During the last 5 years, have you been outside of Oregon for 60 days in a row or more? If yes, complete the following for each residence in the past five years.	☐Yes ☐No

Start Date	End Date	City	State	Country	Names Used at this residence

24. Have you **ever** been arrested, charged or convicted of a crime? If yes, list all arrests, charges and/or convictions (adult and juvenile) and the outcome, regardless of how long ago. For each arrest, charge or conviction you list, provide as much information as possible regarding the incident. *Attach additional pages as needed.*	☐Yes ☐No

Date	Charge, arrest or conviction	Outcome (e.g., conviction, dismissal)	City	County	State

25. If you have potentially disqualifying conditions or convictions, the Background Check Unit must consider several factors to determine the risk of vulnerable individuals and your fitness to hold the position. Please provide any information about the details of your criminal history, yourself, your training, education, work history, treatment and circumstances since your criminal history. *Attach additional pages as needed.*

26. I understand that criminal record and abuse checks will be completed on me. My signature authorizes the ACHP and Background Check Unit to request and receive any juvenile, police, court or investigation reports needed to complete this background check. If I fail to list any part of my history, I understand my application may be closed or denied due to false statement. In the event that potentially disqualifying abuse is discovered, I will be notified at the address listed above and asked to provide additional information.	***Initials:*** _____
27. If you have out-of-state identification, lived outside of Oregon in the past 5 years or have ever been arrested or convicted of a crime in Oregon or elsewhere, or if you are requested to submit fingerprints for any other reason, you are responsible for submitting electronic fingerprints within 10 days of the state Background Check Unit's request, which ACHP will email or mail to you. If you do not provide electronic fingerprints within the specified time, this application may be closed. By initialing here, you acknowledge that once this application is closed, a new application and fees must be submitted.	***Initials:*** _____
28. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be closed or I may be denied the position. I understand the background check may be repeated while I hold this position.	***Initials:*** _____

Signature:_____ Date: _____

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Health History and Physician/Nurse Practitioner's Statement

Applicant's name:_____ **Birth date:** _____

Part 1 ***(*Pages 1-2) To be completed by the operator and given to physician or nurse practitioner for review.***

Part 2 ***(Pages 3-4)*** **To be completed by physician or nurse practitioner and return directly to ACHP.**

Current physician or nurse practitioner's name:

Date of exam by this medical provider **/** **/**

Review of symptoms (check all that apply)

Do you have any of the following?		Do you have any of the following?		Have you ever had?	
Weight loss/weight gain		Tiredness or significant fatigue		A car accident	
Fevers/headaches		Unable to tolerate heat or cold		Loss of consciousness	
Difficulty with vision		Short of breath with or without		Loss of vision	
Dizziness/vertigo		Palpitation or skipped beats		Abnormal heart rhythm	
Seasonal allergies		Chest pain or tightness		Seizure	
Sinus problems		Indigestion/heartburn		Panic attacks	
Wheezing		Abdominal pain		Head injury	
Cough		Diarrhea/constipation		Stroke	
Back pain		Irregular periods		Paralysis	
Joint pain or swelling		Frequent urinary tract infections		Back injury	
History of broken bones		Kidney stones		Psychiatric treatment	
		Skin problems (rash, psoriasis)			

Vaccination history/communicable diseases* *(Have you had?)*

	Yes	No	Unsure
The standard series of childhood vaccinations?			
The disease "chicken pox" or the chicken pox vaccine *(Varicella)*?			
A tetanus/diphtheria booster shot within the last 10 years?			
Hepatitis B vaccination *(this is a series of 3 injections spaced several months apart)*?			
The disease "Tuberculosis"?			
A positive tuberculosis test *(also called PPD or Tine Test)*			
Vaccination against tuberculosis with BCG *(this is uncommon in the United States)*?			

http://www.cdc.gov/vaccines/spec-grps/hcw.htm - Healthcare Personnel Vaccination Recommendations

Current medical or psychiatric conditions *(Those that you are currently experiencing and receiving treatment for)*

	Please list N/A	Date of onset		*Please list*	Date of onset
1			2		
3			4		
5			6		

Note: Check N/A (not applicable) if you are not experiencing or receiving treatment for any Medical or Psychiatric condition.

Medications/treatments ☐ N/A (Please include prescription medications, non-prescription medications, vitamins, herbal supplements, medical marijuana and treatments)

1		2	
3		4	
5		6	
7		8	

Question: *Do you have any allergies to medications or other substances? If yes, please list.*

Note: Check N/A *(not applicable)* if you are not on any medication prescription, non-prescription medications, vitamins, herbal supplements or Medical Marijuana or do not have any medication allergies.

Occupational assessment

	Yes	No	Unsure
1. Do you have any physical limitations *(such as lifting or mobility restrictions)* that may limit the type of resident/client you can care for? *(If yes explain)*			
2. Do you currently use illicit/illegal drugs? *(If yes explain)*			
3. How many alcoholic drinks do you consume per day? Per Week?			
4. Have you ever had an occupational injury/illness before (back strain, chemical exposure, or infection due to human blood and body fluid exposure)? *(If yes explain)*.			
5. Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your job? *(If yes explain)*			

I declare under penalty of perjury that all statements made in this Health History are true and complete. I authorize the Multnomah County, Adult Care Home Program and my physician, nurse practitioner or clinic to exchange any medical information that is pertinent to my ability to provide care to the frail, elderly or disabled adults and operate my adult foster home(s). I understand that my failure to provide accurate and complete information may result in the denial of my application or other administrative sanctions against my adult foster home license.

Applicant's signature *Date*

PART 2 - THIS FORM IS TO BE COMPLETED AND RETURNED TO THE ADULT CARE HOME PROGRAM BY THE HEALTH CARE PROVIDER. Return completed form to: Adult Care Home Program, 421 SW Oak St, suite 650 Portland Or 97204

Applicant's name: _____ **Exam date:** / /
Please print applicant's name

INSTRUCTIONS TO THE HEALTH CARE PROVIDER:

The individual named above is under consideration for a care provider position in an adult care home. A completed Physician/Nurse Practitioner's Statement is required every two years or more frequently if needed, as a means of documenting that the applicant is in satisfactory health to provide care and services to older adults and adults with disabilities.

ALL CAREGIVERS, must be physically, mentally and emotionally able to care for individuals who may require varying levels of assistance with their Activities of Daily Living.

The job requires physical, mental and emotional health sufficient to perform the following duties safely. This list is not all inclusive but provided to give you a sense of the care requirements the above individual will be required to provide.

Physical activities include, changing bedding, mattresses and/or moving furniture in resident rooms; lifting, rotating and assisting residents who are partially or totally incapacitated; providing personal care in eating, dressing, hair and body care, communication, toileting, bathing, oral care, etc.; operating equipment such as wheelchairs, lifting devices, mechanized beds and other related medical device; medication administration and medical treatments per physician order and under nursing delegation supervision.

Emotional/mental activities being able to patiently listen and provide non-judgmental support and empathy, quick clear thinking and can remain calm in an emergency, able to be assertive and act as a resident advocate, able to follow rules and procedures directing them on the resident care and safety and able to deal in a supportive and empathetic manner to difficult situations.

Physician/nurse practitioner questions

1. How long have you known this person?
   ☐ Just met today ☐ Months Years ☐ Other *(describe below)*
   _____

2. What information did you review to complete this Health History Assessment? *(Check all that apply)*
   ☐ Interview – date occurred
   ☐ Physical exam – date occurred
   ☐ Medical record review – please be specific
   ☐ Diagnostic testing and studies – please be specific

3. In your assessment have you identified any physical conditions or impairments that would limit this person's ability to care for, lift or physically support the movement of heavy, frail, elderly or disabled adults?
   ☐ No ☐ Yes **If yes, please explain below and include what information and/or documentation you relied on.**

Please rate the applicants' ability to:

	UNKNOWN	POOR	AVERAGE	GOOD
Lift over 50lbs on a regular/daily basis:	☐	☐	☐	☐
Cope with high levels of stress on a daily basis:	☐	☐	☐	☐
Stand for long periods of time:	☐	☐	☐	☐
Communicate Verbally with Medical Personnel:	☐	☐	☐	☐
Follow instructions:	☐	☐	☐	☐

4. This person listed their current medication(s)/treatment(s) on page 2 of this document. After your review of that medication/treatment list have you identified any issues that might reduce this individual's capacity to safely care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

5. Based on your health assessment and review of the applicant's health inventory, does this person have any mental or emotional problems that might hinder his/her ability to care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

6. Based on your health assessment and review of the applicant's health inventory, does this person have any cognitive problems that might hinder his/her ability to care for frail, elderly or disabled adults?

☐ No ☐ Yes **If yes, please explain below.**

7. Are there any indications this person ever abused drugs or alcohol?

☐ No ☐ Yes

If yes, please explain below and include treatment received if any.

8. In your opinion, would this applicant benefit from any evaluation and/or monitoring in either of the following areas:

Physical health concerns ☐ No ☐ Yes Mental/emotional health concern ☐ No ☐ Yes

If yes, please explain below.

9 Do you have any concerns that have not been addressed in this form?

☐ No ☐ Yes **If yes, please explain below.**

Thank you for completing this form. Your assessment and statement are used to ensure resident and caregiver safety in the Adult Foster Home setting.

Physician Attestation and Signature

I do hereby attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omissions, or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature stamps are not accepted

Signature and credentials of physician or nurse practitioner Date Phone number

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Foster Home Medicaid Provider Enrollment Agreement

For providers with foster homes for developmentally disabled children or child welfare foster homes, complete sections A and B only. For all other providers, complete all sections as applicable.

Section A — Foster home information

Foster home street address:	City:	State:	ZIP code + 4:
1234 N MAIN ST	PORTLAND	OR	97222
Mailing address *(if different)*:	City:	State:	ZIP code + 4:
SAME			
Foster home phone number:	Provider number: (STATE NUMBER)		Number of beds:
(503) 555 - 5555	555444		4

Name to be listed on license/certificate: JASPER BROWN

Applicant has applied for *(must choose **one**)*:

☐ **Initial license or certification** ☒ **Renewal license or certification**

To operate the following type of foster homes *(must choose **one**)*:

☒ **Adult foster home for older or physically disabled adults** governed by OARs 411-050-0600 through 411-050-0690.

☐ **Adult foster home for developmentally disabled adults** governed by OARs 411-360-0010 through 411-360-0310.

☐ **Child foster home for developmentally disabled children** governed by OARs 411-346-0100 through 411-346-0230.

☐ **Child welfare foster home** governed by OARs 413-200-0301 through 413-200-0396.

SAMPLE

Section B — Provider information

Disclosure of Social Security numbers is required pursuant to 42 USC 405(c)(2)(C)(i) for the purpose of establishing identification, 42 CFR 455.104 for the purpose of exclusion verification, and 26 CFR 301.6109-1 for the purpose of reporting tax information.

Provider information

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
BROWN	JASPER	Y	MR
Street address:	**City:**	**State:**	**Zip code + 4:**
1234 N MAIN ST	PORTLAND	OR	97222
Social Security Number (SSN):	**Date of birth:**	**Home phone number:**	
333-11-4444	01/01/63	(503) 555-3333	
Percentage of ownership: 100 %	**Officer title:** OPERATOR		

Do you live in the foster home? ☒ Yes ☐ No
Do you provide care to residents? ☒ Yes ☐ No
Are you related to any other owner? ☐ Yes ☒ No
If yes, how are you related *(spouse, parent, child, sibling)*? NA
Have you been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☒ No

Co-provider information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
NA			
Street address:	**City:**	**State:**	**Zip code + 4:**
Social Security Number (SSN):	**Date of birth:**	**Home phone number:**	
Percentage of ownership: %	**Officer title:**		

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*?
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Resident manager 1 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
NA			
Social Security Number (SSN):	**Date of birth:**	**Home phone number:**	

Resident manager 2 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
NA			
Social Security Number (SSN):	**Date of birth:**	**Home phone number:**	

Section C1 — Business information

The Department of Human Services (DHS) may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the provider's name as listed in Section B or under the Taxpayer Identification Number (TIN) as chosen below.

Official business name as filed with the Oregon Secretary of State or IRS: NA

Type of business as filed with the Oregon Secretary of State or IRS:

☐ Sole proprietor ☐ Partnership ☐ Limited partnership
☐ Corporation (corp., Inc.) ☐ S corporation (SCORP) ☐ Limited liability corporation (LLC)

Employer Identification Number (EIN) or Tax Identification Number (TIN): _____

Do you want information reported to the IRS, when required, under your: ☐ SSN ☐ TIN/EIN

Section C2 — Information for other persons with ownership or controlling interest

Provide the following information for all managing employees, all corporate officers and all persons who have ownership or controlling interest in the foster home. Attach a separate paper for additional persons as necessary. **Do not include the applicant or co-applicant.** This information is required by 42 CFS 455.104 and 42 CFR455.106.

1. Name: NA | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security Number:

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*? _____
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

2. Name: NA | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security number (SSN):

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*? _____
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Section C3 — Information on ownership or controlling interest related to outside entities

Provide the following information for all **other businesses** in which the persons or entities listed in Section B and Section C2 also have five percent (5%) or more ownership or controlling interest in any subcontractor of the foster home. Attach a separate paper for additional entities as necessary. This information is required by 42 CFR 455.104.

Business name: NA			
Business street address:	City:	State:	ZIP code + 4:
Phone number:	TIN/EIN:	Percentage of ownership: %	

Agreement

This Provider Enrollment Agreement, hereinafter referred to as the Agreement, sets forth the conditions for being enrolled as a Foster Home Provider with the State of Oregon Department of Human Services (DHS) and for receiving Medicaid payment for services provided within a foster home. This Agreement is valid for the term of provider's current license or certification and shall remain in effect during the term of the license or certification unless terminated earlier in writing in accordance with the terms of this Agreement.

1. Provider understands and agrees that all information submitted in the Agreement is true and accurate. Information disclosed by the provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS, may be punished by administrative law, criminal law or both, including but not limited to revocation of the provider's license or certification to operate a foster home and receive payment for Medicaid services.
2. Provider must notify DHS of any changes to the information contained in this Agreement within thirty (30) days of the date of the change. Provider understands and agrees DHS may terminate this Agreement if it determines that the provider did not fully and accurately make any disclosure required in this Agreement or if the provider fails to notify DHS of any changes within thirty (30) days.
3. Provider agrees to comply with all applicable licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules, and agrees to fully comply with all Oregon statutes and regulation applicable to the provider's scope of service as well as the program-specific rules for the type of home for which provider is licensed or certified.
4. Provider understands and agrees that prior authorization is required before placement of any client and that payment will not be issued if prior authorization was not granted.
5. Provider understands and agrees to comply with client specific regulations when admitting a client from a program other than the program under which the provider is licensed or certified.

Client specific regulations are as follows:

- Adults who are older or physically disabled — OARs 411-050-0655(1)(a)-(b), (4)(a) and (b)(A)-(E), (5)(m)(A)-(H) and (6)(f), (h), (i)(A-C) and (k).

- Adults who are developmentally disabled — OARs 411-360-0120(9); 411-360-0130(4)(f), and (6)(d); 411-360-0160(1)-(10); 411-360-0170(2)(b)-(c), (4)(a)(A)-(E), and (b)(A)-(F); 411-360-0180(5), (10), (16)(a)-(f), and (17); 407-045-260(1)(a)-(j) and (14); and 407-045-0300(1)-(5).

- Children who are developmentally disabled — OARs 411-346-0180(2)(a)-(j), (3)(h); 411-346-0190(1)(c), (e), and (g), (2)(b), (4)(c), and (e), (7)(a)-(h), (8)(a)-(j), (9)(a)-(n), (11)(e)-(j); and 411-346-0200(4)(d)-(f), (5)(a)-(d), and (g).

6. Provider agrees to provide the care and services necessary to ensure the health, safety and well-being of clients in the provider's home and to maximize clients' ability to function at the highest level of independence as possible. Provider understands and agrees payment may be denied or subject to recovery if care or services were not authorized or not provided in accordance with the requirements specified in this Agreement.

7. Provider will receive notification of individual client service rates. Provider agrees to accept the rate authorized by DHS as payment in full. Provider is not to charge the client or any person responsible for the client any additional amounts beyond the DHS determined client service contribution. Payment for ongoing services shall be processed after the end of the month in which service was provided. Payment for services that have ended shall be processed after the end of services. Provider understands and agrees payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs, or that employs or is managed by excluded individuals or entities (ORS 443.004). As a condition of payment, provider must meet and maintain compliance with the Provider Rules, OAR 407-120-0300 through 407-120-0380 and 407-120-1505.

8. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place. Notification must be submitted a minimum of sixty (60) days prior to the termination date. Termination by the Provider must be sent to the local office and to DHS. Provider must also submit appropriate and timely notice to all residents affected by this termination as outlined in the applicable program specific rules.

9. Department of Human Services (DHS) may terminate this Agreement at any time by submitting a notice in person or by certified mail with the specific date on which termination will take place.

10. Provider understands and agrees provider is not employed by any division of DHS or any Area Agency on Aging (AAA) and shall not for any purposes be deemed an employee of the State of Oregon or any AAA except as set forth in ORS 443.733 *(collective bargaining)*. Provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. Provider is solely responsible for its acts or omissions, including the acts or omissions of its own officers, employees or agents.

11. Provider shall indemnify and defend the State of Oregon, any Oregon county, Area Agency on Aging, Community Developmental Disability Program, their respective agencies and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever arising out of, or relating to the acts or omissions of provider or its officers, employees, subcontractors or agents under this Agreement.

12. Provider has fully read, understands and agrees to comply with the terms and conditions set forth in this Agreement. Payment of claims will be from federal and state funds. Any falsification in connection with the receipt of payment for services may be prosecuted under federal and state law.

By signing below, provider declares that he or she understands and agrees that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for administrative sanction as provided by Oregon statute or rule.

Jasper Brun — Provider signature

4/20/15 — Date

Co-provider signature — Date

Local licensing authority use only

☐ OIG verified ☐ GSA (SAM) verified ☐ Approved Background Check
☐ OSBN verified ☐ CNA Registry verified ☐ Business Registry verified

License start date: _____ License end date: _____

DHS staff or designee signature and title: _____ Date: _____

Choose the type of license approved

☐ **DD – Adults with developmental disabilities:**
- ☐ Level one foster home
- ☐ Level 2B foster home
- ☐ Level 2M foster home
- ☐ Limited foster home

☐ **APD – Older adults and adults with physical disabilities:**
- ☐ Commercial adult foster home
- ☐ Limited foster home
- ☐ Ventilator-assisted care foster home

An AFH licensee can only live in one AFH. If this licensee has multiple AFH's, confirm that the system indicates this provider lives in no more than one AFH.

List the names of each person identified in Sections B and C2 who live in the home and provide care to residents. Check CNT – Controlling interest, COO-CO – Provider, OFF – Officer of business or PRI – Provider. If none, check N/A.

1. Licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
2. Co-licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
3. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
4. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
5. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
6. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A

DHS
Oregon Department of Human Services
Office of Licensing and Regulatory Oversight

Foster Home Medicaid Provider Enrollment Agreement

For providers with foster homes for developmentally disabled children or child welfare foster homes, complete sections A and B only. For all other providers, complete all sections as applicable.

Section A — Foster home information

Foster home street address:	City:	State:	ZIP code + 4:
Mailing address *(if different):*	City:	State:	ZIP code + 4:
Foster home phone number*:*	Provider number:		Number of beds:

Name to be listed on license/certificate: _____

Applicant has applied for *(must choose one)*:

☐ Initial license or certification ☐ Renewal license or certification

To operate the following type of foster homes *(must choose one)*:

☐ Adult foster home for older or physically disabled adults governed by OARs 411-050-0600 through 411-050-0690.

☐ Adult foster home for developmentally disabled adults governed by OARs 411-360-0010 through 411-360-0310.

☐ Child foster home for developmentally disabled children governed by OARs 411-346-0100 through 411-346-0230.

☐ Child welfare foster home governed by OARs 413-200-0301 through 413-200-0396.

Section B — Provider information

Disclosure of Social Security numbers is required pursuant to 42 USC 405(c)(2)(C)(i) for the purpose of establishing identification, 42 CFR 455.104 for the purpose of exclusion verification, and 26 CFR 301.6109-1 for the purpose of reporting tax information.

Provider information

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Street address:	City:	State:	Zip code + 4:
Social Security Number (SSN):	Date of birth:	Home phone number:	
Percentage of ownership: %	Officer title:		

Do you live in the foster home? ☐ Yes ☐ No
Do you provide care to residents? ☐ Yes ☐ No
Are you related to any other owner? ☐ Yes ☐ No
If yes, how are you related *(spouse, parent, child, sibling)*? _____
Have you been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Co-provider information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Street address:	City:	State:	Zip code + 4:
Social Security Number (SSN):	Date of birth:	Home phone number:	
Percentage of ownership: %	Officer title:		

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*? _____
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Resident manager 1 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Social Security Number (SSN):	Date of birth:	Home phone number:	

Resident manager 2 information *(if applicable)*

Last name *(as known by IRS)*:	First name *(as known by IRS)*:	MI:	Title: choose one
Social Security Number (SSN):	Date of birth:	Home phone number:	

Section C1 — Business information

The Department of Human Services (DHS) may report information to the Internal Revenue Service (IRS) and the Oregon Department of Revenue under the provider's name as listed in Section B or under the Taxpayer Identification Number (TIN) as chosen below.

Official business name as filed with the Oregon Secretary of State or IRS:

Type of business as filed with the Oregon Secretary of State or IRS:

☐ Sole proprietor ☐ Partnership ☐ Limited partnership
☐ Corporation (corp., Inc.) ☐ S corporation (SCORP) ☐ Limited liability corporation (LLC)

Employer Identification Number (EIN) or Tax Identification Number (TIN):

Do you want information reported to the IRS, when required, under your: ☐ SSN ☐ TIN/EIN

Section C2 — Information for other persons with ownership or controlling interest

Provide the following information for all managing employees, all corporate officers and all persons who have ownership or controlling interest in the foster home. Attach a separate paper for additional persons as necessary. **Do not include the applicant or co-applicant.** This information is required by 42 CFS 455.104 and 42 CFR455.106.

1. Name: | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security Number:

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*?
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

2. Name: | Date of birth:

Street address: | City: | State: | ZIP code + 4:

Phone number: | Social Security number (SSN):

Percentage of ownership: % | Officer title:

Does this person live in the foster home? ☐ Yes ☐ No
Does this person provide care to residents? ☐ Yes ☐ No
Is this person related to any other owner? ☐ Yes ☐ No
If yes, how are they related *(spouse, parent, child, sibling)*?
Has this person been convicted of a criminal offense related to the person's involvement in any program under Medicare, Medicaid or Child Welfare? ☐ Yes ☐ No

Section C3 — Information on ownership or controlling interest related to outside entities

Provide the following information for all other businesses in which the persons or entities listed in Section B and Section C2 also have five percent (5%) or more ownership or controlling interest in any subcontractor of the foster home. Attach a separate paper for additional entities as necessary. This information is required by 42 CFR 455.104.

Business name:			
Business street address:	City:	State:	ZIP code + 4:
Phone number:	TIN/EIN:	Percentage of ownership: %	

Agreement

This Provider Enrollment Agreement, hereinafter referred to as the Agreement, sets forth the conditions for being enrolled as a Foster Home Provider with the State of Oregon Department of Human Services (DHS) and for receiving Medicaid payment for services provided within a foster home. This Agreement is valid for the term of provider's current license or certification and shall remain in effect during the term of the license or certification unless terminated earlier in writing in accordance with the terms of this Agreement.

1. Provider understands and agrees that all information submitted in the Agreement is true and accurate. Information disclosed by the provider is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in this Agreement or contained in any communication supplying information to DHS, may be punished by administrative law, criminal law or both, including but not limited to revocation of the provider's license or certification to operate a foster home and receive payment for Medicaid services.
2. Provider must notify DHS of any changes to the information contained in this Agreement within thirty (30) days of the date of the change. Provider understands and agrees DHS may terminate this Agreement if it determines that the provider did not fully and accurately make any disclosure required in this Agreement or if the provider fails to notify DHS of any changes within thirty (30) days.
3. Provider agrees to comply with all applicable licensing, certification and regulatory requirements as set forth by federal and state statutes, regulations, and rules, and agrees to fully comply with all Oregon statutes and regulation applicable to the provider's scope of service as well as the program-specific rules for the type of home for which provider is licensed or certified.
4. Provider understands and agrees that prior authorization is required before placement of any client and that payment will not be issued if prior authorization was not granted.
5. Provider understands and agrees to comply with client specific regulations when admitting a client from a program other than the program under which the provider is licensed or certified.

   Client specific regulations are as follows:

   - Adults who are older or physically disabled — OARs 411-050-0655(1)(a)-(b), (4)(a) and (b)(A)-(E), (5)(m)(A)-(H) and (6)(f), (h), (i)(A-C) and (k).

- Adults who are developmentally disabled — OARs 411-360-0120(9); 411-360-0130(4)(f), and (6)(d); 411-360-0160(1)-(10); 411-360-0170(2)(b)-(c), (4)(a)(A)-(E), and (b)(A)-(F); 411-360-0180(5), (10), (16)(a)-(f), and (17); 407-045-260(1)(a)-(j) and (14); and 407-045-0300(1)-(5).

- Children who are developmentally disabled — OARs 411-346-0180(2)(a)-(j), (3)(h); 411-346-0190(1)(c), (e), and (g), (2)(b), (4)(c), and (e), (7)(a)-(h), (8)(a)-(j), (9)(a)-(n), (11)(e)-(j); and 411-346-0200(4)(d)-(f), (5)(a)-(d), and (g).

6. Provider agrees to provide the care and services necessary to ensure the health, safety and well-being of clients in the provider's home and to maximize clients' ability to function at the highest level of independence as possible. Provider understands and agrees payment may be denied or subject to recovery if care or services were not authorized or not provided in accordance with the requirements specified in this Agreement.

7. Provider will receive notification of individual client service rates. Provider agrees to accept the rate authorized by DHS as payment in full. Provider is not to charge the client or any person responsible for the client any additional amounts beyond the DHS determined client service contribution. Payment for ongoing services shall be processed after the end of the month in which service was provided. Payment for services that have ended shall be processed after the end of services. Provider understands and agrees payment cannot be made to any individual or entity that has been excluded from participation in federal or state programs, or that employs or is managed by excluded individuals or entities (ORS 443.004). As a condition of payment, provider must meet and maintain compliance with the Provider Rules, OAR 407-120-0300 through 407-120-0380 and 407-120-1505.

8. Provider may terminate this Agreement at any time by submitting a written notice in person or by certified mail with the specific date on which termination will take place. Notification must be submitted a minimum of sixty (60) days prior to the termination date. Termination by the Provider must be sent to the local office and to DHS. Provider must also submit appropriate and timely notice to all residents affected by this termination as outlined in the applicable program specific rules.

9. Department of Human Services (DHS) may terminate this Agreement at any time by submitting a notice in person or by certified mail with the specific date on which termination will take place.

10. Provider understands and agrees provider is not employed by any division of DHS or any Area Agency on Aging (AAA) and shall not for any purposes be deemed an employee of the State of Oregon or any AAA except as set forth in ORS 443.733 *(collective bargaining)*. Provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. Provider is solely responsible for its acts or omissions, including the acts or omissions of its own officers, employees or agents.

11. Provider shall indemnify and defend the State of Oregon, any Oregon county, Area Agency on Aging, Community Developmental Disability Program, their respective agencies and their officers, employees and agents from and against all claims, suits, actions, losses, damages, liabilities, costs and expenses of any nature whatsoever arising out of, or relating to the acts or omissions of provider or its officers, employees, subcontractors or agents under this Agreement.

12. Provider has fully read, understands and agrees to comply with the terms and conditions set forth in this Agreement. Payment of claims will be from federal and state funds. Any falsification in connection with the receipt of payment for services may be prosecuted under federal and state law.

By signing below, provider declares that he or she understands and agrees that violation of any of the terms and conditions of this Agreement constitute grounds for termination of this Agreement and may be grounds for administrative sanction as provided by Oregon statute or rule.

Provider signature _____ Date _____

Co-provider signature _____ Date _____

Local licensing authority use only

☐ OIG verified ☐ GSA (SAM) verified ☐ Approved Background Check
☐ OSBN verified ☐ CNA Registry verified ☐ Business Registry verified

License start date: _____ License end date: _____

DHS staff or designee signature and title: _____ Date: _____

Choose the type of license approved

☐ DD – Adults with developmental disabilities:
- ☐ Level one foster home
- ☐ Level 2B foster home
- ☐ Level 2M foster home
- ☐ Limited foster home

☐ APD – Older adults and adults with physical disabilities:
- ☐ Commercial adult foster home
- ☐ Limited foster home
- ☐ Ventilator-assisted care foster home

An AFH licensee can only live in one AFH. If this licensee has multiple AFH's, confirm that the system indicates this provider lives in no more than one AFH.

List the names of each person identified in Sections B and C2 who live in the home and provide care to residents. Check CNT – Controlling interest, COO-CO – Provider, OFF – Officer of business or PRI – Provider. If none, check N/A.

1. Licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
2. Co-licensee's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
3. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
4. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
5. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A
6. Other union member's name: _____ Date of birth: _____
   ☐ CNT ☐ COO – CO- ☐ OFF ☐ PRI ☐ N/A