

Adult Family Home License Application

Notice to Applicant

The Department of Social and Health Services (DSHS) issues an adult family home license to individuals and entities to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services (Revised Code of Washington (RCW) 70.128.010). No individual or entity shall operate or maintain an adult family home in this state without a license (RCW 70.128.050).

The adult family home license is issued to the licensee (operator) and is not transferable (Washington Administrative Code (WAC) 388-76-10010(3)(a)). The licensee/operator is ultimately responsible for the daily operational decisions of the adult family home and the care of residents (WAC 388-76-11055).

Application Instructions

When completing this application you must:

- Type or print clearly in BLUE or BLACK ink.
- Answer all questions or mark "N/A" if the question does not apply. You must complete the entire application (i.e., all of the sections must be filled out and/or marked) and you must include the required documents; otherwise your application will be returned to you with no further action.
- If you have questions about completing the application, please call the Applications Unit at 360-725-2420.
- Submit all required supporting documentation.
- Use the application checklist to make sure you have submitted all required documentation. Include the checklist with your application when you mail it to the department.
- Sign the completed application.
- Make a copy of your application and all supporting documents for your files.
- Mail your completed application, required documents, and one check for:
 - \$2750.00 for: 1) an application for a proposed Adult Family Home (AFH) that is not currently licensed; or 2) an application to relocate (move) your AFH license to a new location.
 - \$700.00 for change of ownership.

For US Mail:

ALTSA Finance and Contracts
PO Box 45600
Olympia, WA 98504-5600

For Federal Express:

ALTSA Finance and Contracts
4450 10th Ave. SE (Blake West)
Lacey, WA 98503

- You must notify the Applications Unit in writing if any information in the adult family home application changes before the home is licensed. Mail the corrected information to: Business Analysis & Applications Unit, PO Box 45600, Olympia, WA 98504-5600. Be sure to identify the facility name, address, and applicant name.

Adult Family Home Application Processing and Timelines

It is extremely important that the application is complete and that all documentation is provided with the application. Otherwise, there may be a delay in the application and licensing process.

If the application is incomplete, you will receive a written notice of what is incomplete. You will have 60 days from the date of that written notice to complete the application and return it to our office. If you do not respond within 60 days of the date of our request, your application may become void. You are encouraged to contact the office five working days after returning the information requested by the department in order to verify receipt of the information.

The amount of time it takes to process an application will vary based on several factors (for example, whether the application is filled out completely, all of the required documents are attached. If the department has questions or concerns about the information associated with this application and the number of applications in process). It could take 60 days or more to process an application from the time it is determined to be "complete".

The department will call the applicant (or the entity representative) when the department is ready to schedule the licensing inspection and also if/when the home is licensed.

Adult Family Home (AFH) Application Checklist

(This checklist must be included with the application)

NAME OF PROPOSED ADULT FAMILY HOME	NAME OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE
<p>Please check below to show that you have included the following with your application.</p> <p><input type="checkbox"/> \$2750.00 (new license, relocation)</p> <p><input type="checkbox"/> \$700.00 (change of ownership)</p> <ul style="list-style-type: none"> • Enclose <u>one</u> check or money order for the applicable fee made payable to: <u>Washington State Treasurer</u>. • If no payment is included, the application will be returned without processing. <p><input type="checkbox"/> Adult Family Home License Relinquishment Letter completed by current licensee (if applicable). Access and print this form DSHS 10-412 at http://www.dshs.wa.gov/forms/eforms.shtml.</p> <ul style="list-style-type: none"> • This is required if you are submitting an application to become the licensee of an AFH that is currently licensed to someone else. You must include this form signed by the current licensee saying that they are willing to relinquish/give up their adult family home license if and when your license is approved <u>and</u> that they will continue to operate the home until the applicant is licensed. <p><input type="checkbox"/> Copy of 60-day change of ownership (CHOW) notice given to residents (if applicable).</p> <ul style="list-style-type: none"> • This is required if you are submitting an application to become the licensee of an AFH that is currently licensed to someone else. The current owner must provide written notice to the department, residents or applicable resident representatives, sixty calendar days prior to the date of the proposed change of ownership. WAC 388-76-10106 <p><input type="checkbox"/> Copy of 30-day notice on change of location or address.</p> <ul style="list-style-type: none"> • This is required if you are moving your licensed AFH to another location (home). WAC 388-76-10110 <p><input type="checkbox"/> Copy of your AFH Orientation Certificate or a copy of your current adult family home license. Orientation is required for the provider, and spouse co-applicant, State Registered Domestic Partner co-applicant, or entity representative.</p> <ul style="list-style-type: none"> • Completion of the AFH Orientation class must have been within the last 12 months <u>unless</u> you currently have an AFH license or have had an AFH license within the last 12 months. • The application will be returned as incomplete if the orientation certificate shows that the class occurred more than 12 months from the date that the application was received by the department. In that case you will have to retake the class before submitting another application. 	
For AL TSA Fiscal Use Only	For AL TSA Application Unit Use Only

- Copy of your Washington state business license showing that your trade name has been registered with the Department of Revenue and showing the Unified Business Identifier (UBI) number for the proposed licensee for this application.
- A UBI is a 9-digit number issued to individuals and companies doing business in Washington State. To get a UBI number, fill out a Business License Application. To obtain this form, contact Department of Revenue, Business Licensing Service, at telephone number: 1-800-451-7985. The form is available at <http://bls.dor.wa.gov/file.aspx>.
- Copy of a document issued by the Internal Revenue Service (IRS) showing the Employer Identification Number (EIN) for the proposed licensee for this application.
- The applicant must have a federal EIN before applying for an adult family home license.
 - An EIN is a 9-digit number assigned to businesses from the Internal Revenue Service for filing and reporting purposes.
 - To apply for an EIN, fill out Form SS-4, Application for Employer Identification Number, which is available at local Social Security Administration offices. Or, contact the IRS, Business and Tax Specialty, at telephone number: 1-800-829-4933. The SS-4 form is also available at <http://www.irs.gov>
- More information on EINs is found at <http://www.irs.gov/businesses>
Select Business Topics, then Employer ID Number.
- Copies of documents showing that the applicant provider and co-applicant, entity representative, and resident manager meet the minimum qualifications for licensure (see section 9).
- Copies of training documents showing that the applicant provider and co-applicant, entity representative, and resident manager have met the manager specialty training requirements (See section 10) if you plan to care for residents with dementia, developmental disabilities, and/or mental illness.
- Copy of Home Care Aide Certification, if applicable.
- Completed background authorization forms for all persons listed in section 12. The form is available at: <http://www.dshs.wa.gov/BCCU/bccuforms.shtml>
- For any person in Section 12 who has had a DSHS fingerprint background check done since January 1, 2012, obtain a copy of the FBI fingerprint background result letter and include it in the application.
- Copy of the adult family home floor plan.
- Copies of the following required policies
- Medication disposal; and
 - Accepting Medicaid residents; and
 - Abuse, neglect and exploitation; and
 - Contacting emergency medical services
- Copy of your adult family home Notice of Rights and Service Requirements for:
- Private pay residents
 - Medicaid eligible residents, if you decide to admit residents whose stay is paid by the state
- Copy of completed Disclosure of Services form (DSHS 10-508) as required in 70.128.280 RCW.
- Copy of your adult family home disaster plan. This plan needs to cover the potential disasters that could happen at your home and how you will care for your residents during and after the disaster.
- Letter from all property owners stating they are aware the home is being used as an adult family home.
- Please note:** If you have a septic tank, you will be required to have approval by DOH or your local health authority for your home to be used as an adult family home. For information on the requirements in your area please go to: www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions.aspx
- If you are applying for a license for an adult family home that is not currently licensed:
- Printed directions or a map showing how to drive to the AFH from the nearest city, highway, or freeway.
 - Copy of the AFH building inspection checklist that shows the home “passed” its building inspection. The form is available at: <http://www.adsa.dshs.wa.gov/professional/afh/bldginspections.htm>

Check all that apply:

- This is an application for a proposed adult family home that is not currently licensed.
- This is an application to change the license status of this currently licensed adult family home. For example, changing from a sole proprietorship to a corporation, or if spouse co-providers divorce.
- This is an application for an adult family home that is currently licensed to someone else, and I am applying to be the new provider for this adult family home. (If this box is checked, include the completed, signed Adult Family Home License Relinquishment Letter (DSHS 10-412) from the current provider which states that they will relinquish/give up their license if and when this license is approved.)
- This is an application to relocate (move) my/our AFH license to a new location.
 - Current AFH address: _____
 - Current AFH license number: _____
 - Number of residents to be moved to the new location: _____
- I/we** currently have (how many?) _____ licensed adult family homes.
If you checked this box, list all your current license number(s):

Check one:

The adult family home (AFH) application is being submitted by a(n):

- Individual (to be licensed under my name only as a sole proprietor)
- Married couple or State Registered Domestic Partner couple (to be licensed together as sole proprietor)
- For Profit Corporation
- Nonprofit Corporation
- Partnership
- Limited Liability Company (LLC)

Please note:

Enforcement Action

Under RCW 70.128.160, the department has the authority to take one or more of the following enforcement actions: 1) Refuse to issue a license; 2) Impose a condition on the license; 3) Impose civil penalties; 4) Suspend, revoke, or refuse to renew a license; or 5) Suspend admissions by imposing a stop placement. The law authorizes the department to impose enforcement actions for a variety of issues including for not complying with the law or rules adopted under this rule. This could include failure to pay the annual license fee when due.

Under RCW 70.128.065, the department shall only accept and process a license application:

- For a second adult family home unless the applicant has maintained the first adult family home license for at least 24 months with no enforcement actions as listed in RCW 70.128.160(2).
- For a third or additional home when 12 months have passed since the previous adult family home license was granted and no enforcement actions have been taken against any of the currently licensed homes.
- For providers of multiple adult family homes when less than 12 months have passed since obtaining the prior license, if the applications are due to the change in ownership of existing adult family homes that are currently licensed and the department has taken no enforcement actions against the applicant's currently licensed adult family homes during the twelve months prior to application.

Adult Family Home License Application

Section 1. Information About the Proposed Adult Family Home				
1. NAME OF PROPOSED ADULT FAMILY HOME				
2. STREET ADDRESS		CITY	COUNTY	STATE ZIP CODE
3. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)			CITY	STATE ZIP CODE
4. TELEPHONE NUMBER	5. CELL PHONE NUMBER		6. FAX NUMBER	
Physical address for applicant (if the applicant is not living at the address for the proposed adult family home).				
7. ADDRESS		CITY	STATE	ZIP CODE
You must notify the department if the above address changes.				
Section 2. Property Owner Information				
1. Does the individual applicant / entity representative own this home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
NAME OF PROPERTY OWNER				
PROPERTY OWNER'S ADDRESS		CITY	STATE	ZIP CODE
2. Will the property owner take an active interest in the operation of the adult family home by charging rent as a percentage of the business, providing management services, providing care to residents or have any other involvement in the adult family home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide a written explanation of active interest in the adult family home.				
Section 3. Unified Business Identifier (UBI) Number and Federal Employer Identification Number (EIN)				
The following numbers are <u>required</u> for the license application. For information on getting these numbers, see the application instructions.				
1. APPLICANT'S UBI NUMBER		2. APPLICANT'S EIN NUMBER		
		-		
Section 4. Entity				
Fill out this section ONLY if an <u>entity</u> is applying for the license. An entity is a corporation, partnership, limited liability company (LLC), or non-profit. If you are applying as a sole proprietor, mark the N/A box and go to section 6. <input type="checkbox"/> N/A (I am applying as an individual)				
1. LEGAL NAME OF ENTITY (NAME LISTED ON THE EIN AND UBI)		2. TELEPHONE NUMBER	3. FAX NUMBER	
4. MAILING ADDRESS		CITY	STATE	ZIP CODE
Section 5. Individuals Affiliated with Applicant (For Entities Only)				
Fill out this section ONLY if an entity (a corporation, partnership, limited liability company (LLC), or non-profit) is applying for the license. If you are applying as a sole proprietor, skip this section and go to section 6.				
NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP
				%
				%
				%
				%
				%

Section 6. Individual Applicant / Entity Representative

The individual applicant or the entity representative must complete this section. An entity representative is the person designated by the entity as responsible for the daily operation of the proposed adult family home

1. NAME OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE (LAST, FIRST, MIDDLE)			
2. NAME OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)			
3. DATE OF BIRTH		4. SOCIAL SECURITY NUMBER	
5. E-MAIL ADDRESS		6. TELEPHONE NUMBER IF NOT LIVING IN THE PROPOSED AFH	
7. ADDRESS IF NOT LIVING IN THE PROPOSED AFH		CITY	STATE ZIP CODE

Section 7. Spouse or State Registered Domestic Partner

- 1. Do you have a spouse or State Registered Domestic Partner (SRDP)? Yes No
- 2. Do you want your spouse or State Registered Domestic Partner to be listed on the license for this proposed adult family home?
 Yes No Not Applicable - I am applying as an entity (e.g. corporation) or limited liability company (LLC).

Notes:

- If you checked "yes" to the question immediately above, both you and your spouse or SRDP must meet all licensing requirements.
- Couples considered legally married under Washington state law may not apply for separate licenses for each spouse.
- State Registered Domestic Partners may not apply for separate licenses for each SDRP.
- To be included as a SRDP, both the applicant and SRDP co-applicant must be registered with the Office of the Secretary of State, Corporations Division. For information about State Registered Domestic Partners, see www.secstate.wa.gov.

Complete below whether or not the spouse or SRDP is to be listed on the license.

3. NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER (LAST, FIRST, MIDDLE)	
4. NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)	
5. DATE OF BIRTH	6. SOCIAL SECURITY NUMBER

Section 8. Resident Manager Information

This section is to be completed for the person who will be the resident manager of the proposed adult family home.

- Every adult family home application must list a resident manager for the proposed adult family home.
- A resident manager is a person employed or designated by the provider or entity representative to manage the adult family home.
- The resident manager can be the applicant, co-applicant, or other qualified person. However, a person cannot be a resident manager for more than one adult family home.
- If you are the entity representative/individual applicant and the Resident Manager, you must complete this section.
- If our records show that the person you have listed as a resident manager for this proposed adult family home is currently a resident manager for another adult family home, your application will be considered incomplete and you will be asked to designate another qualified person to be the resident manager of your proposed adult family home.

1. NAME OF RESIDENT MANAGER (LAST, FIRST, MIDDLE)	
2. NAME OF RESIDENT MANAGER AS IT APPEARS ON BIRTH CERTIFICATE (LAST, FIRST, MIDDLE)	
3. DATE OF BIRTH	4. SOCIAL SECURITY NUMBER

Section 9. Minimum Qualifications

Please mark with an "X" in the table below that documentation is provided with this application to verify that each of the following people meets the minimum qualifications:

- Sole proprietor (only mark this column when applying as a sole proprietor)
- Spouse co-applicant or state registered domestic partner co-applicant
- Entity representative (If applying as an entity such as LLC, Corp, etc.)
- Resident Manager (This column must be marked)

Include copies of the required documentation for each person. For the educational requirements (in a through f below), only one piece of proof is required.

**IF YOU HAVE MORE THAN ONE ROLE,
MARK THE BOXES FOR EACH ROLE**

	SOLE PROPRIETOR	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
Has a United States high school diploma or general education development certificate, or any English translated government document of the following:				
a. Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction (which is the equivalent of grades 1-12 in the U.S.). If so, you must include a copy of the diploma (foreign language and English translation) and proof of the required number of hours (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Graduation from a foreign college, foreign university, or United States accredited community college with a two-year diploma, such as an Associate's degree; If so, you must include a copy of the diploma (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Admission to, or completion of course work at a foreign or United States accredited college or university for which credit were awarded; If so, you must include a copy of the transcript(s) of credits (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Graduation from a foreign or United States accredited college or university, including award of a Bachelor's degree; If so, you must include a copy of the diploma (foreign language and English translation).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Admission to, or completion of postgraduate course work at a United States accredited college or university for which credits were awarded, including award of a Master's degree; If so, you must include a copy of the transcript(s) of credits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Successful passage of the United States board examination for registered nursing or any professional medical occupation for which college or university education was required. If so, attach a copy of the license. Note: This does <u>not</u> include a Certified Nursing Assistant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 9. Minimum Qualifications (Continued)

	SOLE PROPRIETOR	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
<p>Has obtained Home Care Aide Certification as required by WAC 388-112-0106 (include copy of Home Care Aide certificate from Department of Health (DOH) for applicant, co-applicant, entity representative, and resident manager).</p> <p align="center">OR</p> <p>Is exempt from Home Care Aide Certification, under RCW 18.88B.041. If exempt, include copy of the following for the applicant, co-applicant, entity representative, and resident manager: 1) Qualifying professional credential; or 2) Verification of employment between 01/01/2011 and 01/06/2012; and certificate of required caregiving training. Employment verification may be submitted on form DOH 675-006 or submit a letter from the employer indicating dates of employment, and the worker's job title and description.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has completed the department approved Administrator Training for adult family homes, under WAC 388-112-0270 and WAC 388-76-10064. (Not required for resident manager.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has completed at least one thousand hours in the previous sixty months of successful direct caregiving experience obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home. Note: This information will be verified.</p> <p align="center">OR</p> <p>Has a current, valid physician license under Chapter 18-71 RCW, osteopathic physician license under Chapter 18-57 RCW, osteopathic physician assistant license under Chapter 18-57A RCW, physician assistant license under Chapter 18-471A RCW or RN, ARNP or LPN license under Chapter 18-79 RCW. If so, attach a copy of the license. Please note if you possess one of the above licenses, no attestation is required. AND</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has a valid cardiopulmonary resuscitation (CPR) certificate as required in Chapter 388-112 WAC. This training is usually provided by the American Heart Association and the Red Cross but there may be other training entities. An on-line course does not meet this requirement. Copy both sides of the card/certificate if two sides are completed. AND</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has a valid first-aid card or certificate as required in Chapter 388-112 WAC. First aid is usually done at the same time as CPR. Copy both sides of the card/certificate if two sides are completed.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Has a Valid Food Safety Certificate IF YOU HAVE 1) completed the Core Basic Training OR 2) completed Food Safety Course during the Fundamentals of Caregiving OR 3) has a valid DOH Food Handler's Card.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 10. Specialty Training

Check one (Note: If you are applying for a change of ownership for an existing adult family home, you may need a specialty designation to care for one or more of the residents in the home.):

- I do not intend to admit and care for residents with dementia, mental illness and/or developmental disabilities. If you check this box, please go to Section 11.
- I intend to admit and care for residents with dementia, mental illness and/or developmental disabilities. If you check this box or decide that you want to admit and care for residents with dementia, mental illness and/or developmental disabilities, the individual applicant, spouse co-applicant or state registered domestic partner co-applicant, entity representative, and resident manager must have the required manager “specialty” training. **Attach the appropriate specialty training certificates described below for each person and for each type of specialty training. Each person in the columns below must have the required training in order to receive the specialty designation on the license.**

**IF YOU HAVE MORE THAN ONE ROLE,
MARK THE BOXES FOR EACH ROLE**

	INDIVIDUAL APPLICANT	SPOUSE CO-APPLICANT OR STATE REGISTERED DOMESTIC PARTNER CO-APPLICANT	ENTITY REPRESENTATIVE	RESIDENT MANAGER
<u>Manager Dementia Specialty Training</u> – The specialty training certificate must show the class was for “manager” dementia specialty training. If the class occurred before July 2002, the certificate MUST show that the person completed the 20 hour “dementia caregiving specialty training” class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Manager Mental Health Specialty Training</u> – The specialty training certificate must show the class was for “manager” mental health specialty training. If the class occurred before July 2002, the certificate must show that the person completed the 20 hour “mental health caregiving specialty training class.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disability Specialty Training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 11. Previous Licensing or Contracting Experience

1. Has any person or entity named in this application ever owned, held an interest in, managed, or held a license for an adult family home, assisted living facility, nursing home, or other business providing services to children, vulnerable adults, or persons with mental illness or developmental disabilities? Yes No

If “yes”, provide the information below for each person or entity in this application: (Attach additional pages if needed)

FACILITY A	NAME OF PERSON	FACILITY LICENSE TYPE	NAME OF FACILITY
	FACILITY CITY AND STATE	POSITION HELD	DATES HELD
FACILITY B	NAME OF PERSON	FACILITY LICENSE TYPE	NAME OF FACILITY
	FACILITY CITY AND STATE	POSITION HELD	DATES HELD
FACILITY C	NAME OF PERSON	FACILITY LICENSE TYPE	NAME OF FACILITY
	FACILITY CITY AND STATE	POSITION HELD	DATES HELD

Section 11. Previous Licensing or Contracting Experience (Continued)

2. Has any person or entity named in this application ever held a recognized social services contract to provide services to children, vulnerable adults, or persons with mental illnesses or developmental disabilities? Yes No

If "yes", provide the information below for each person or entity in this application. **Do not list client information; list applicant information:** (Attach additional pages if needed)

NAME OF PERSON OR ENTITY REPRESENTATIVE	TYPE OF CONTRACT	STATE	DATES HELD

3. Has any person or entity named in this application now or previously been under investigation by a professional licensing agency, Division of Licensing Resources, a state licensing or contracting agency, Division of Children and Family Services, Child Protective Services, Adult Protective Services or the police for any disciplinary action or for abuse, neglect, exploitation or misappropriation of property of any person? Yes No

4. Has any person or entity named in this application now or previously been denied a contract, license or license renewal to operate a facility providing care to adults or children? Yes No

5. Has any person or entity named in this application been certified, licensed or contracted with to provide care or services to adults or children, and:

- Had such certification or license revoked, suspended, suspended with stay, enjoined, or imposed with conditions, civil fine or stop placement? Yes No
- Had a Medicaid or Medicare provider agreement revoked, cancelled, suspended or not renewed? Yes No
- Relinquished or returned such certification or license; or did not seek the renewal of certification or license when notified by the state agency of initiation of denial, suspension, cancellations, or revocation of certificate, license, or contract? Yes No

If the answer is "yes" to questions 3, 4 or 5 of Section 11, you must provide the following on a separate sheet of paper and attach it to this application:

- Name of the individual;
- Effective date of license or certification;
- Date of action taken;
- Type of action taken;
- Name and address of facility;
- Name and address of agency that took the action; and
- Circumstances.

Section 12. Background Information

List and attach a completed Background Authorization form for each of the following:

- Individual Applicant
- Individual Applicant's Entity Representative's Spouse or State Registered Domestic Partner
- Entity Owners, Partners, Officers, Directors (Includes all members of a corporation)
- Entity Representative
- Resident Manager
- Landlord of the proposed adult family home if they will live in the adult family homes.
- Persons age 11 or older who currently or who will live in the adult family home.

You can print out the Background Authorization form from: <http://www.dshs.wa.gov/BCCU/bccuforms.shtml>

Section 12. Background Information (Continued)

Do not complete Background Authorizations for other children age 10 or under. Do not include residents.
 Background Authorization forms must have ALL blanks filled in or the license application will be returned without action.
Previous results from a background inquiry are not accepted.

Note: If you do not include background authorization forms for anyone listed above, the department will return the application as incomplete and will not proceed with licensing activities until the background authorizations have been provided.

1. NAME OF PERSONS (ATTACH ADDITIONAL SHEETS OF PAPER IF NEEDED)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	ROLE IN AFH (N/A IF NONE)

2. Are you or your household member currently employed by the Department of Social and Health Services?
 Yes No

If "yes" to the above question:

- List the name of the person(s) in this application that is employed by the Department of Social and Health Services: _____
- List the job title of the person(s) in this application that is employed by the Department of Social and Health Services: _____

Are you or your household member currently employed by the Aging and Long-Term Support Administration?
 Yes No

Do you or your household member's job duties with the Department of Social and Health Services include:

- Placement of persons in an adult family home? Yes No
- Authorizing payments for any resident's care and services in an adult family home? Yes No

If you answered "yes" to any of the above questions in item 2, please call the Applications Unit at (360) 725-2420.

3. List below any person named in this application who is over the age of 18 and has lived in another state in the past three years.

If none, check here **N/A**

NAME OF PERSON	OUT OF STATE ADDRESS	DATES LIVED IN OTHER STATE(S) (MONTH/YEAR)

Section 13. Financial Assessment Information

Answer this section for the individual applicant, spouse co-applicant or state registered domestic partner co-applicant, entity applicant, entity representative, resident manager, partners, officers, directors, and owner of 5% or more of the entity. Place an "x" in the appropriate "yes" or "no" boxes below. Attach additional sheets of paper if needed.

1. Have you ever filed for bankruptcy? Yes No
 If "yes", provide the following:

NAME OF THE INDIVIDUAL	TYPE OF BANKRUPTCY <input type="checkbox"/> CH 7 <input type="checkbox"/> CH 13	STATE FILED	DATE FILED	DATE CONCLUDED
NAME OF THE INDIVIDUAL	TYPE OF BANKRUPTCY <input type="checkbox"/> CH 7 <input type="checkbox"/> CH 13	STATE FILED	DATE FILED	DATE CONCLUDED

2. Have any judgments ever been filed against you or the entity? Yes No
 If "yes", provide the following:

NAME OF THE INDIVIDUAL	DATE OF JUDGEMENT	COUNTY AND STATE
DESCRIBE THE CIRCUMSTANCES		

Section 14. Consent to Release and / or Use Confidential Information

The individual applicant, spouse, or state registered domestic partner co-applicant, entity representative, entity's officers, director or owner, and resident manager must each sign this section. **The spouse or state registered domestic partner, whether or not they are to be listed on the license, must sign below.**

I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of licensing. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-01 WAC).

I understand that the department may check the credit of an individual applicant, an entity applicant, a business and its principals; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I understand the department may perform an individual credit history check for all individuals associated with an application to determine financial solvency per RCW 70.128.120 (10), WAC 388-76-1000, WAC 388-76-10020, 388-76-10960(21), and 388-76-10970.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information. If you have more than one role, sign in multiple places.

NAME OF INDIVIDUAL APPLICANT	SIGNATURE	DATE
NAME OF SPOUSE OR STATE REGISTERED DOMESTIC PARTNER	SIGNATURE	DATE
NAME OF ENTITY REPRESENTATIVE	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF OFFICER, DIRECTOR, OWNER OF 5% OR MORE OF THE APPLICANT:	SIGNATURE	DATE
NAME OF RESIDENT MANAGER	SIGNATURE	DATE

Section 14. Consent to Release and / or Use Confidential Information (Continued)

Name(s) and signature(s) of any other person age 11 or older who currently or who will live, work, volunteer, or otherwise have unsupervised access to residents in the adult family home.

NAME (PLEASE PRINT)	SIGNATURE	DATE
NAME (PLEASE PRINT)	SIGNATURE	DATE
NAME (PLEASE PRINT)	SIGNATURE	DATE
NAME (PLEASE PRINT)	SIGNATURE	DATE
NAME (PLEASE PRINT)	SIGNATURE	DATE
NAME (PLEASE PRINT)	SIGNATURE	DATE

Section 15. Certification

I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for licensure of an adult family home are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the applicant, spouse co-applicant, or State Registered Domestic Partner co-applicant, entity representative, and resident manager are at least 21 years of age or older.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available for the licenser.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, termination of a license, or other sanctions as allowed by law.

I understand that the department may check the credit of an individual applicant, an entity applicant, a business and its principals; obtain a credit report; and verify any responses provided. The department will use such information and may disclose this information to other parts of the department as appropriate. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law.

I understand and agree that the information I give to the department will be used to verify the information in this application. Any information I give to the department may be used by the department for this purpose.

I understand that the department will perform an individual credit history check for all applicants per RCW 70.128.120.

I understand that if my application for an adult family home license is denied, I may request an administrative fair hearing within 28 days of receiving the denial letter from DSHS.

I have read Chapters 70.128, 70.129, 74.34 RCW, and 388-76, 388-112, and 388-110 WAC, and any other applicable laws and rules.

Notice to Applicant

The Department of Social and Health Services (DSHS) issues an adult family home license to individuals and entities to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services (Revised Code of Washington (RCW) 70.128.010). No individual or entity shall operate or maintain an adult family home in this state without a license (RCW 70.128.050).

The adult family home license is issued to the licensee (operator) and is not transferable (Washington Administrative Code (WAC) 388-76-10010(3)(a)). The licensee/operator is ultimately responsible for the daily operational decisions of the adult family home and the care of residents (WAC 388-76-11055).

If/when I am licensed:

- I understand that any resident manager I employ must meet the requirements of RCW 70.128.120 and WAC 388-76-10130.
- No residents receiving care and services in the adult family home will be subject to discrimination on the basis of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.
- If any residents need delegated care, I will make sure that the care is delegated by a registered nurse, according to state law and rules.
- I will use the approved floor plan and will not change the use of any room until the local building inspector, if required, and the Residential Care Services field office have reviewed and approved the changes.
- I will not exceed the approved capacity of the adult family home, and will contact the Residential Care Services field office before making any capacity changes.

I certify and declare under penalty of perjury under the laws of the State of Washington that the information in this application and all of the supporting documents are true and correct to the best of my knowledge.

SIGNATURE OF INDIVIDUAL APPLICANT OR ENTITY REPRESENTATIVE AUTHORIZED TO COMPLETE THIS APPLICATION	DATE
PRINT NAME	DAYTIME TELEPHONE NUMBER
CITY AND STATE WHERE SIGNED	

Signature of Spouse Co-Applicant or State Registered Domestic Partner Co-Applicant (only complete this area if applying as a married couple or state registered domestic partnership).

SIGNATURE

DATE

PRINT NAME

DAYTIME TELEPHONE NUMBER

CITY AND STATE WHERE SIGNED