# Department of County Human Services

**Aging, Disability and Veterans Services Division, Adult Care Home Program**

## Renewal Application

TSELOT TAFESSE NEGASH
642 NE 195TH AVE
PORTLAND OR 97230

06/01/2020

Please return your application for License Number **11147** on or before **07/19/2020**. Your license expires on **09/17/2020**. Failure to submit a completed application at least 30 days prior to expiration may result in processing delays, late payments, or a closed license.

**Directions:**
Please make sure all forms are complete and attach required verifications. Your fees are non-refundable and failure to submit a timely or complete application may result in closure or denial.

1. Sign and date the application.
2. The correct payment amount must be received with this application. Please use the fee determination form included with this packet.
3. Complete a Background Check Request form (BCR) and attach copies of each applicant's photo ID. BCRs are required for all persons 16 years or older who live, work or make use of the facilities on a frequent basis. NOTE: New BCR applicants must present their BCR forms and photo ID in person. Please remember that ACHP does not conduct background checks on residents or residents' visitors.
4. Complete the Medicaid Provider Enrollment Agreement if you would like to accept Medicaid payments. You must complete this form annually.
5. Attach copies of all continuing education credit certificates and the State approval for the training. You do not need to attach state approval for Multnomah County sponsored classes.
6. Attach copies of current First Aid, CPR, and any other required certifications for yourself and all others working in the home (for example OIS, Vent Training) .
7. Submit the Staffing Plan included with this packet. The plan must reflect current and accurate staffing sufficient to meet the needs of residents and must reflect adequate time off for providers.
8. Make sure all caregiver records are complete and available (checklist, workbook, and training log). Your licenser will ask to view them during the renewal inspection.
9. Please make sure you have a completed and signed Back-Up Operator Agreement Form. Your Back-Up Operator must be a currently licensed Operator or approved Resident Manager in Multnomah County.

Please note: If a complete renewal application packet is not submitted before the license expiration date, the ACHP shall treat the home as an unlicensed home (Refer to MCAR 023-040-620).

**PLEASE MAKE A COPY OF YOUR COMPLETED APPLICATION FOR YOUR RECORDS.**

# Care Home Worksheet

This form is part of your renewal application. Our records show that the people on this form work, live, or visit your home on a regular basis (excluding residents you care for). Please carefully follow the instructions below:

For each person listed below who occupies or works in the home, please fill out requested information and submit required verification documents (see Renewal Application directions). If the person no longer occupies or works in the home, mark the checkbox in their section.

For anyone living, working, and/or visiting your home on a regular basis who is NOT listed below, please provide their name and the required information at the end of this form.

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**Operator - DD: Tselot Tafesse Negash**

Role Expires: **09/17/2020** Medicaid: **Yes**

BCR Expires: **02/11/2021** Physician Statement Form Expires: **09/25/2021**

Certificate Expirations: CPR: **07/24/2020** First Aid: **07/24/2020**

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**Caregiver - DD: Berhanemeskel Asefa**

Role Expires: **07/05/2020**

BCR Expires: **07/06/2021**

Certificate Expirations: CPR: **01/11/2020** First Aid: **01/11/2020**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

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**Caregiver - DD: Samuel Hailu Enkosa**

Role Expires: **05/22/2021**

BCR Expires: **04/02/2022**

Certificate Expirations: CPR: **03/29/2020** First Aid: **03/29/2020**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

**Caregiver - DD: Eden Abate Kassahun**

Role Expires: **12/09/2020**

BCR Expires: **10/04/2021**

Certificate Expirations: CPR: **Missing** First Aid: **Missing**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

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**Caregiver - DD: Getnet Tesfaye Tibebu**

Role Expires: **11/12/2020**

BCR Expires: **11/13/2021**

Certificate Expirations: CPR: **11/10/2020** First Aid: **11/10/2020**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

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**Caregiver - DD: Meti Kumera Tolesa**

Role Expires: **09/30/2020**

BCR Expires: **08/28/2020**

Certificate Expirations: CPR: **10/09/2020** First Aid: **10/09/2020**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

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**Caregiver - DD: Tesfaye Amina Uka**

Role Expires: **12/30/2020**

BCR Expires: **12/23/2021**

Certificate Expirations: CPR: **Missing** First Aid: **Missing**

How many hours is this caregiver alone in the home? _____

Typical number of hours worked in a week: _____

Employer has verified Provider is not on the Medicaid Exclusions List: Yes ☐ No ☐
To verify, go to *https://exclusions.oig.hhs.gov*

Employment Ended: ☐ Last date worked:_____

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**Household Member - DD: Fikirte S Rumicho**

BCR Expires: **03/17/2020**

No longer in the home: ☐ Last date in home:_____

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For anyone living, working, and/or visiting your home on a regular basis who is NOT listed above, please provide the following information and the required documentation.

| Name | Date of Birth | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**LICENSE RENEWAL APPLICATION**
Adult Care Home Program
Multnomah County

AGING, DISABILITY & VETERANS SERVICES
209 SW 4th Avenue, 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.
- ☐ 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 licensed / certified in another county or state? Yes ☐ No ☐

**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?<br>If YES, by WHOM? _____<br>Reason: _____ | Yes ☐ No ☐ |
| Have you ever had a founded or substantiated finding of abuse or neglect of an adult or child?<br>If YES, Explain: _____<br>_____<br>_____ | Yes ☐ No ☐ |

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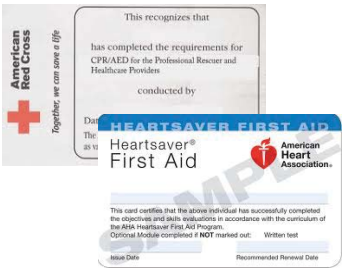
| | |
|---|---|
| In the last 12 month have you had any unsatisfied **judgments**, **liens**, or **lawsuits** filed against you in which a claim for money or property (including eviction) is made against you?<br><br>If YES, Explain: _____<br>_____<br>_____ | Yes ☐ No ☐ |
| In the past 12 months have you ever filed **bankruptcy** or been **delinquent** (behind) with your property taxes, utilities or household bills?<br><br>If YES, Explain: _____<br>_____<br>_____ | 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 |
|---|---|---|
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| | | |
| 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?<br>If yes, where: _____<br>(Company Name / Name of School) (Address) (Telephone)<br>What is your schedule for school and/or work? Include the number of hours you are engaged in these extra activities each week.<br>Explain: _____<br>_____<br>_____<br>_____ | Yes ☐ No ☐ |

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

| | |
|---|---|
| Name: | |
| Address: | |
| City/State/Zip: | |
| Home phone:<br>( ) - | Cell phone:<br>( ) - |

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

| | |
|---|---|
| Name: | |
| Address: | |
| City/State/Zip | |
| Home phone:<br>( ) - | Cell phone:<br>( ) - |

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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?<br>If YES, please provide contact info for the property Owner:<br>Name: _____ Phone: _____<br>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?)<br>If YES, WHO? _____<br>_____ | 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 |
|---|---|---|
| | | |

# Adult Care Home Staffing Plan for _____ to _____

| | | |
|---|---|---|
| Operator: | Resident Manager: | License #: |
| Adult Care Home Address: | | Phone: |
| Live-in Care Providers: ☐ Operator ☐ Resident Manager ☐ Caregivers: | | |

List all caregivers including Operator, Resident Manager, and caregivers, and write their **scheduled work hours**. The schedule must reflect coverage 24 hours a day, 7 days a week, and must provide scheduled time off for live-in providers/caregivers.

| Caregiver Name | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
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|---|---|
| If Operator or Resident Manager works outside the home, list work days and hours: | |
| Operator Signature: | Date: |



*Retention: Retain staffing plans with facility records for at least 3 years.*

***DO NOT POST THIS PAGE***

## Secondary/One-on One Caregiver Schedule for _____ to _____

Identify individual residents by initials. List days and times when secondary caregivers provide one-on-one or specialized care for individual residents. If caregiving tasks cannot be scheduled at specific times, indicate the number of hours for each day. Provide a brief description of the tasks. This document should reflect the exceptional rate payment worksheet (SDS 0514A) or other documentation for specialized care.

| Resident Initials | Secondary / One-on-One Caregiver Name | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| Tasks: | | | | | | | | |
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| Tasks: | | | | | | | | |
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| Tasks: | | | | | | | | |
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| Tasks: | | | | | | | | |

**Adult Care Home Program**
Aging, Disability and Veterans Services Division
209 SW 4th Avenue Suite 650
Portland, OR 97204
Phone: 503-988-3000

# Authorization for Use and Disclosure of Individual Information

| Applicant's Legal Last Name: | First Name: | Middle Initial: | Date of Birth: |
|---|---|---|---|
| Other Names Used: | | Social Security Number (optional) | |

**By signing this form, I am authorizing the Multnomah County Adult Care Home Program to verify the information submitted in my application packet. I understand that this may include disclosure of the following information by the record holder:**

| | |
|---|---|
| Credit history & financial information | Medical/Health History |
| Employment history | Substantiated abuse/neglect history |
| Other licensing or certification records including compliance history | Child abuse/neglect and child foster home certification history |

**Purpose of the requested use or disclosure:** The applicant named above has applied to operate, manage or work in an adult care home serving older adults and people with disabilities, adults with developmental disabilities, or adults receiving mental health and addiction services. The information received will be used to evaluate the applicant's ability to provide care for elderly or dependent individuals and to operate, manage or work in an adult care home.

## APPLICANT ACKNOWLEDGEMENTS

- I was given the opportunity to ask questions about this form and what it does.
- I understand that state and federal law may protect information disclosed to Multnomah County. I understand that information will be used for the purpose of evaluating my application with Multnomah County Adult Care Home Program. I understand what this authorization means and I approve of the disclosures listed.
- I understand that I can revoke (cancel) this authorization at any time and that revocation (cancellation) will not apply to any information already disclosed. I understand that I or the person legally authorized to act on my behalf is required to submit the cancellation request in writing to the Adult Care Home Program.
- I understand that federal or state law prohibits re-disclosure of HIV and AIDS information, mental health, drug and alcohol diagnosis, treatment records, referral information, or vocational rehabilitation records without another authorization.
- I understand that the information not subject to limitation on re-disclosure as noted immediately above may be subject to re-disclosure and no longer protected under federal or state law.
- I understand that signing this authorization is a condition of licensure.
- I understand that declining to sign may prevent Multnomah County from determining licensure eligibility. Declining to sign the authorization will not affect treatment, payment, enrollment or eligibility for benefits provided to me by the record holder.

| RELEASE TO | |
|---|---|
| Multnomah County Adult Care Home Program<br>209 SW 4th Avenue, Suite 650<br>Portland OR 97204 | Telephone Number: 503-988-3000<br>Fax Number: 503-988-5722<br>Email: advsd.adult.carehomeprogram@multco.us |
| ATTENTION: | Email: |

**This authorization is valid for one year from the date of signing unless otherwise specified**

_____ _____

*Signature of Applicant/Individual Authorizing Release* *Date*

_____

*Printed Name of Applicant/Individual Authorizing Release*

---

*Complete this section only if requested by the Adult Care Home Program*

## AUTHORIZATION FOR RELEASE OF SPECIALLY PROTECTED INFORMATION

In addition to the above authorization, I am authorizing the record holder to disclose the following *specific* information about me effective as of the date signed below:

| RELEASE FROM | |
|---|---|
| **Release from record holder** (*individual, employer, agency, school, medical or other provider*): | |
| Name of Recordholder: | Phone Number: |
| Address: | Email: |
| Specific information to be disclosed (please be as detailed as possible): | |
| **Specially protected information:** (Additional laws relating to use and disclosure may apply if the information to be disclosed contains any of the types of records or information listed in this box. I understand that this information will not be disclosed *unless I place initials in the box next to the information*)<br>☐ Mental Health _____ ☐ Alcohol/drug diagnoses, treatment, referral _____ ☐ HIV/AIDS _____ | |

| RELEASE TO | |
|---|---|
| Multnomah County Adult Care Home Program<br>209 SW 4th Avenue, Suite 650<br>Portland OR 97204 | Telephone Number: 503-988-3000<br>Fax Number: 503-988-5722<br>Email: advsd.adult.carehomeprogram@multco.us |
| ATTENTION: | Email: |
| Expiration date or event*: | Mutual exchange:<br>☐ Yes ☐ No |

** This authorization is valid for one year from the date of signing unless otherwise specified*

_____ _____

*Signature of Applicant/Individual Authorizing Release* *Date*

_____

*Printed Name of Applicant/Individual Authorizing Release*

# Back-up Operator Agreement

All Adult Care Come 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 Information** | | |
|---|---|---|
| Applicant/Operator: | Resident Manager: | |
| Facility Phone: | Cell Phone: | |
| Facility Address: | | |
| License Number: | Classification: | Population: |

**Back-up Operator:** The designated Back-up Operator must: 1) Be an approved licensed Operator or Resident Manager in Multnomah County. 2) Be a licensed Operator or Resident Manager serving the same population and classification (i.e. APD Operator cannot back-up DD operator) and 3) Not act as the Resident Manager and back-up Operator for the same home.

| | | |
|---|---|---|
| Back-up Operator or Resident Manager: | | |
| Home Phone: | Cell Phone: | |
| Address: | | |
| License Number: | Classification: | Population: |

## Orientation to the Adult Care Home:

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 named 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
- ☐ Oriented to resident medications and means to access the locked medication storage
- ☐ Oriented to Emergency Preparedness Plan for the home
- ☐ Can make arrangements if needed for any delegated nursing tasks
- ☐ Has a current role approval from the Adult Care Home Program, including background check
- ☐ Has the authority to hire qualified caregivers on behalf of the Operator

*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 Adult Care Home Program.*

| | |
|---|---|
| Applicant/Operator Signature: | Date: |
| Back-up Operator Signature: | Date: |

# ADULT CARE HOME OPERATOR OR RESIDENT MANAGER
## Health History and Physician / Nurse Practitioner's Statement

**Applicant's Name:** _____ Birth Date: / /

| **Part 1 – Instructions:** | **Return Completed Form To:** |
|---|---|
| 1. **The applicant is required to complete all of PART 1** *(pages 1-2).*<br>2. **The physician or nurse practitioner is required to complete PART 2** *(pages 3-5).* | Multnomah County Adult Care Home Program<br>209 SW 4th Avenue, Suite 650<br>Portland OR 97204 |

| **Current medical provider** | **Date of last physical exam** |
|---|---|
| **Current provider's name** | / / |
| **Last physical exam by any 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 | ☐ | Unable to tolerate heat or cold | ☐ | Loss of consciousness | ☐ |
| Headaches | ☐ | Short of breath with or without exertion | ☐ | Heart attack | ☐ |
| Difficulty with vision | ☐ | Palpitation or skipped beats | ☐ | Loss of vision | ☐ |
| Dizziness/vertigo | ☐ | Chest pain or tightness | ☐ | Abnormal heart rhythm | ☐ |
| Seasonal allergies | ☐ | Indigestion/heartburn | ☐ | Seizure | ☐ |
| Sinus problems | ☐ | Abdominal pain | ☐ | Panic attacks | ☐ |
| Wheezing | ☐ | Diarrhea/constipation | ☐ | Head injury | ☐ |
| Cough | ☐ | Irregular periods | ☐ | Stroke | ☐ |
| Back pain | ☐ | Frequent urinary tract infections | ☐ | Paralysis | ☐ |
| Joint pain or swelling | ☐ | Kidney stones | ☐ | Back injury | ☐ |
| History of broken bones | ☐ | Skin problems (rash, psoriasis) | ☐ | Psychiatric disorder | ☐ |

| **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" (TB)? | ☐ | ☐ | ☐ |
| A positive tuberculosis test (*also called PPD or Tine Test*)? | ☐ | ☐ | ☐ |
| Vaccination against tuberculosis with BCG (*this is uncommon in he 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/or receiving treatment for, including drug/alcohol abuse)*

| | *Please list* or ☐ 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.

### ***Past*** **medical or psychiatric conditions** *(those that you had in the past but recovered from, including drug/alcohol abuse)*

| | *Please list* or ☐ N/A | Date of onset | | *Please list* | Date of onset |
|---|---|---|---|---|---|
| 1 | | | 2 | | |
| 3 | | | 4 | | |
| 5 | | | 6 | | |

Note: Check N/A (not applicable) if you have not experienced and/or received treatment for any Medical or Psychiatric condition .

**Surgeries/hospitalizations** (*list the type of surgery or condition for which you were hospitalized)*

| | *Please list* or ☐ N/A | Date of onset | | Please list | Date of onset |
|---|---|---|---|---|---|
| 1 | | | 2 | | |
| 3 | | | 4 | | |
| 5 | | | 6 | | |

***Question***: When was your last visit to the emergency room?
For what symptom or condition?

Note: Check N/A (not applicable) if you have not had any surgeries or hospitalization or emergency room visits.

**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 prescription medication, non-prescription medications, vitamins, herbal supplements or medical marijuana or do not have any medication allergies. visits.

| **Occupational assessment** | Yes | No | Unsure |
|---|---|---|---|
| 1. Do you have any physical limitations (such as lifting or mobility retrictions) that may limit the type of resident you can care for? If yes, please explain. | ☐ | ☐ | ☐ |
| 2. Do you currently use illicit/illegal drugs? If yes, please explain. | ☐ | ☐ | ☐ |
| 3. How many alcoholic drinks do you consume per day?<br>Per week? | ☐ | ☐ | ☐ |
| 4. Have you ever had an occupational injury/illness before (such as back strain, chemical exposure, or infection due to human blood and body fluid exposure? If yes, please 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, please explain. | ☐ | ☐ | ☐ |

I declare under penalty of perjury that all statements made in this Health History are true and complete. I authorize 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 frail, elderly or disabled adults and operate my adult care home(s). I understand that my failure to provide complete and accurate information may result in the denial of my application or other administrative sanctions against my license or certification.

*Applicant's Signature* *Date*

**PART 2 – THIS FORM IS TO BE COMPLETED AND RETURNED TO THE ADULT CARE HOME PROGRAM BY THE APPLICANT'S PHYSICIAN OR NURSE PRACTITIONER**
**Send completed form to:** Adult Care Home Program, 209 SW 4th Ave., Suite 650, Portland OR 97204

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

The individual named above is under consideration for a care provider position in an Adult Care Home serving older adults and people with disabilities, adults with developmental disabilities, or adults receiving mental health and addiction services. A completed Health History and Physician/ Nurse Practitioner's Statement is required every two years, or more frequently if needed, as a means of documenting that the occupant is in satisfactory health to provide care and services to frail, elderly and disabled adults.

**ALL CAREGIVERS including Owner/Operators, Resident Managers and 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 is 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 devices; medication administration and medical treatments per physician order and under nursing delegation supervision.
- Emotional/mental activities such as being able to patiently listen and provide non-judgmental support and empathy; quick clear thinking; ability to remain calm in an emergency; ability to be able to be assertive and act as a resident advocate; ability to follow rules and procedures directing them on resident care and safety; ability 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 ☐ Mos/Yrs: ☐ 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 including mental health and addiction treatment
   Specify the information reviewed:

   ☐ Diagnostic testing and studies
   Specify the information reviewed:

| 3. Please rate the applicant's ability to: | Unknown | Poor | Average | Good |
|---|---|---|---|---|
| Lift over 50 pounds on a regular/daily basis | ☐ | ☐ | ☐ | ☐ |
| Cope with high levels of stress on a daily basis | ☐ | ☐ | ☐ | ☐ |
| Stand for long period of time | ☐ | ☐ | ☐ | ☐ |
| Communicate verbally with medical personnel | ☐ | ☐ | ☐ | ☐ |
| Follow instructions | ☐ | ☐ | ☐ | ☐ |

4. In your assessment have you identified any physical conditions or impairments that would limit this person's ability to care for, life or physically support the movement of heavy, frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

5. This person has 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:**

6. 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 ability to care for frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

7. Based on your health assessment and review of the applicant's health inventory, does this person have any cognitive problems that might hinder his ability to care for frail, elderly or disabled adults?
☐ No ☐ Yes **If yes, please explain below:**

8. Are there any indications this person ever abused drugs or alcohol?
☐ No ☐ Yes **If yes, please explain below and include treatment received, if any:**

9. In your opinion, would this applicant benefit from any evaluation and/or monitoring in either of the following area?
Physical health concerns ☐ No ☐ Yes Mental/emotional health concerns ☐ No ☐ Yes
**If yes, please explain:**

10. Do you have any concern 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 Adult Care Home settings

**Physician/Nurse Practitioner 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 and credentials of physician or nurse practitioner* | *Date* | *Phone Number*

**Please note: Signature stamps are not accepted**
**Printed name of physician or nurse practitioner:**
Address and phone number:

# BACKGROUND CHECK REQUEST

Adult Care Home Program
Aging, Disability & Veterans Services Division

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

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| 11. Applicant's Personal Email Address | | | 12. Home Phone | | 13. Cell Phone |
| 14. ACHP will send all correspondence to this email address. Check here ☐ if you prefer mailed correspondence. | | | | | |
| 15. Physical Street Address & Apt. Unit | | | 16. Mailing Address *(if different from physical address)* | | |
| City | State | Zip Code | City | State | Zip Code |

**ROLE AND POPULATION**

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. Check the box for your role: ☐ Paid ☐ Unpaid
*Care Provider (ACHP application required)*: ☐ Caregiver ☐ Resident Manager ☐ Operator

*Non-Care Provider (background check only):* ☐ Household Member ☐ Occupant ☐ Volunteer ☐ Housekeeper ☐ Property Maintenance ☐ Other:
For Operator (Name): _____ License: _____
Address:

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

**APPLICANT HISTORY:**

20. Have you ever had a founded report of child abuse or a substantiated abuse or neglect allegation? If yes, **attach a written explanation** and provide information below: ☐Yes ☐No
By which agency? Date:

**BACKGROUND CHECK REQUEST:**

21. Are you requesting an expedited background check or preliminary approval due to an immediate need? If yes, please provide additional information regarding the need: ☐Yes ☐No

22. 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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

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

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

If you have potentially disqualifying conditions or convictions (question #23), 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 that you want the Background Check Unit to weigh when reviewing your background check. ***Attach additional pages as needed.***

24. My submission of this form with my signature authorizes the Oregon Department of Human Services' Background Check Unit (BCU) to initiate a criminal records check, which may include a national criminal records check requiring fingerprints, and to receive the results from Oregon State Police and the FBI. I understand that BCU will complete an abuse check on me. Any information from these checks may be shared with a qualified entity designee at the facility or licensing authority associated with this application.

My submission of this form with my signature authorizes BCU to request and receive any juvenile, police, court or investigation reports needed to complete this background check. In the event BCU discovers potentially disqualifying convictions or conditions, including abuse, BCU may notify me at the address or email I have given to request additional information.

My submission of this form with my signature authorizes BCU to release information given in this background check request or position information to any criminal justice agency or investigative body as needed for investigation, outstanding warrants or supervision requirements

I authorize BCU to process this background check request. I certify that all statements I have made are currently accurate. I understand that I need to disclose any new information that occurs after I submit this form while the background check is still pending. 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 any time while I hold the position for which this check is being done.

Signature:_____ Date: _____

Multnomah County Adult Care Home Program, 209 SW 4th Ave., Suite 650, Portland OR 97204
Phone: 503-988-3000 Fax: 503-988-5722 Email: advsd.adult.carehomeprogram@multco.us

# CAREGIVER APPLICATION

Adult Care Home Program
Aging, Disability & Veterans Services Division

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

☐ **Attach Current Background Check Approval or new ACHP Background Check Request ($15 Fee)**

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

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

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 physical address unless you live in the Adult Care Home.*

| | | |
|---|---|---|
| 12. Applicant's Personal Email Address | 13. Home Phone | 14. Cell Phone |

15. All correspondence will be sent to this email address. Check here ☐ if you prefer mailed correspondence.

| | | | | | |
|---|---|---|---|---|---|
| 16. Physical Street Address & Apt. Unit | | | 17. Mailing Address *(if different from physical address)* | | |
| City | State | Zip Code | City | State | Zip Code |

**EMPLOYMENT INFORMATION:**

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

19. 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: _____

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

**APPLICANT HISTORY:**

21. Have you ever had a founded report of child abuse or a substantiated abuse or neglect allegation? **If yes, attach a written explanation** and provide information below: ☐Yes ☐No
By which agency? Date:

22. 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? ☐Yes ☐No
If yes, by which agency? Date:

23. If yes, has this license or certification ever been denied, suspended or revoked? ☐Yes ☐No
**If yes, attach a written explanation.**

**TRAINING AND QUALIFICATIONS:**

24. Have you ever had a CNA license or other health professional license? ☐Yes ☐No

| Professional License | State: | License Number |
|---|---|---|
| ☐ Certified Nursing Assistant | _____ | _____ |
| ☐ Certified Medical Assistant | _____ | _____ |
| ☐ Licensed Practical Nurse | _____ | _____ |
| ☐ Registered Nurse | _____ | _____ |
| ☐ Other: | _____ | _____ |

25. Education & Training Requirements:

- ☐ APD providers must provide verification that the caregiver workbook has been completed.
- ☐ All providers must provide verification of having taken and passed a mandatory reporter training.
- ☐ All providers who work alone must provide verification of approved First Aid & CPR certification.
- ☐ DD care providers must complete basic training and pass the qualifying test.
- ☐ All DD care providers working in 2B adult care homes must have a current OIS certificate.
- ☐ All renewing DD and MHA caregivers must complete 12 hours of approved CEU's annually.

**BACKGROUND CHECK OR LONG-TERM CARE REGISTRY**

26. If you have an approved background check or Long-Term Care Registry approval for this role and population, please attach a copy. If not, you must also submit a background check request.
*If your background check or Long-Term Care Registry approval expires in 120 days or less, please submit a new Background Check Request.*

**ACHP APPROVED CAREGIVER REGISTRY**

27. The Adult Care Home Program maintains a registry of approved caregivers that is shared with Adult Care Home Operators who have employment opportunities. If you check this box, you will be placed on the registry and may be contacted by Operators with potential employment opportunities.
☐ **Check here if you agree to place your name, phone number and email on this registry.**

**APPLICANT ACKNOWLEDGEMENTS:**

| | |
|---|---|
| 28. 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:*** _____ |
| 29. I understand that providers 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. | ***Initials:*** _____ |
| 30. Providers 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 in English. They shall also possess the ability as determined necessary by the ACHP to provide 24 hour supervision for the population they intend to serve. 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. | ***Initials:*** _____ |
| 31. 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 denied. | ***Initials:*** _____ |
| 32. 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. | ***Initials:*** _____ |

Multnomah County does not discriminate because of race, color, national origin, disability, religion, age, sex/gender, sexual orientation, gender identity and expression, marital status, veteran status, source of income, or any other basis prohibited by federal, state, or local law.

Signature:_____ Date: _____

Multnomah County Adult Care Home Program, 209 SW 4th Ave, Suite 650, Portland OR 97204
Phone: 503-988-3000 Fax: 503-988-5722 Email: advsd.adult.carehomeprogram@multco.us

Department of County Human Services

Multnomah County

Aging, Disability & Veterans Services Division, Adult Care Home Program

# Fee Determination Form

| **Operator:** | **License #:** |
|---|---|
| Number of Beds applying for: X $60.00 per bed | Total Bed Fees: |

ACHP requires an approved ACHP application and approved Background Check for each Operator, Resident Manager, and Caregiver. In addition, all Occupants and Household Members aged 16 or older must also have an approved Background Check (Fitness Determination) from Oregon Department of Human Services' Background Check Unit. List first and last names and include ACHP applications, copies of government-issued photo identification, and copies of approved background checks or new Background Check Requests for all people listed below. All occupants and household members age 16 and older must have an approved background check (pay for first three only).

| Fees:<br>Operator: $15 background check fee<br>Resident Manager: $25 application, $15 background check fee<br>Caregiver: $10 application, $15 background check fee | Application & ID Enclosed | Background Check Request | ACHP Application Fees | Background Check Fee ($15) *if needed* | Total Fees Included With Applications |
|---|---|---|---|---|---|
| Applicant/Operator: | ☐ | ☐ | 0.00 | 15.00 | |
| Resident Manager Name: | ☐ | ☐ | 25.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Caregiver Name: | ☐ | ☐ | 10.00 | 15.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 15.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 15.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 15.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 0.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 0.00 | |
| Occupant Name (16 or older): | | ☐ | 0.00 | 0.00 | |
| Other Non-Caregiver Name: | | ☐ | 0.00 | 15.00 | |
| Other Non-Caregiver Name: | | ☐ | 0.00 | 15.00 | |
| Total Fees Enclosed (*including bed fees*): | | | | | 0 |

*Updated 1.27.2017*

DHS | Oregon Department of Human Services

# 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 2M foster home
- ☐ Level 2B 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