Provider Name: **AFH Address:**

Include this completed form with the application packet submitted to your Licensor.

Adult Foster Home
Provider and Caregiver Qualifications

Provider name	Co-Provider name	RM/Caregiver name	RM/Caregiver name	Caregiver name	Caregiver name	Caregiver name

Background check (expiration date)							
CPR/1st Aid (expiration date)							
Mandatory Abuse (date)							
AFH Basic Test (date)							
Annual training (# of hours completed)							
SB99 Designated point of contact (yes/no)							
SB99 training (date)							
Hire date							
Application asks about founded abuse (yes/no)							
18 years of age or older (yes/no)							
Orientation to home/records (date)							
RN delegation/physician training (date)							
Emergency Plan annual training (date)							
ODL expiration (date - if transporting)							
ISP's/Service Agreement Training (date)							
Individual's initials & ISP date:							
Individual's initials & ISP date:							
Individual's initials & ISP date:							
Individual's initials & ISP date:							
Individual's initials & ISP date:							
Positive Behavior Support Plan (date)							
Individual's initials & PBSP date:							
Individual's initials & PBSP date:							
Individual's initials & PBSP date:							
Individual's initials & PBSP date:							
Individual's initials & PBSP date:							
Safeguarding Interventions/Equipment (date)							

2B: 2 years behavioral experience (yes/no)							
2B: OIS (expiration date)							

2M: RN/LPN or 2 years experience (yes/no)							
2M: 6 of 12 training hours are medical (yes/no)							