RHD Shared Living Provider Application

Please fill out this application and email to kyle.deutsch@rhd.org
Applicants are considered without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-job-related medical condition or disability.

General Information

Date of application: _____

Primary Provider Name: _____

Address: _____

City: _____ State: _____ Zip+4: _____ - _____

Township: _____ County: _____

School District: _____

E-mail Address: _____

Home Phone: ( ) - _____ ☐ No Home (land line) Number

Work Phone: ( ) - _____ Cell Phone: ( ) - _____

Preferred Method of Contact: Home ☐ Work ☐ Cell ☐ E-mail ☐

Have you been a resident of SD for at least 2 years? Yes ☐ No ☐

Have you ever filed for bankruptcy? Yes ☐ No ☐

Alternate Provider Name: _____

Relationship to Primary _____

Address: _____

City: _____ State: _____ Zip: _____

Township: _____ County: _____

School District: _____

Email Address: _____

Home Phone: ( ) - _____ ☐ No Home (land line) Number

Work Phone: ( ) - _____ Cell Phone: ( ) - _____

Preferred Method of Contact: Home ☐ Work ☐ Cell ☐ E-mail ☐

Have you been a resident of SD for at least 2 years? Yes ☐ No ☐

Have you ever filed for bankruptcy? Yes ☐ No ☐

General Information (Continued)

Children/Other Adults Living in the Home:

First and Last Name	Age	Date of Birth	Relationship	Social Security #

If you are the caregiver, parent or guardian of any other individual (child or adult) not living in your home, please list in the space provided below.

First and Last Name	Age	Address (City, State)	Relationship

Personal Information

Primary Provider			Alternate Provider	
		Date of Birth		
		Social Security Number		
Yes ☐	No ☐	U.S. Citizen	Yes ☐	No ☐
Married ☐	Single ☐	Marital Status	Married ☐	Single ☐
		Date of Marriage		
		Religious Affiliation (Optional)		

Education

Highest Grade Completed	
College Degree	
College Major	
Other Training	

Human Services Experience

Have you ever worked in human services?
(including child/adult service systems)? Yes ☐ No ☐

If yes, please indicate in table below

Position	Employer	State	Length of Service	Reason for Leaving
			yrs mos	
			yrs mos	
			yrs mos	
			yrs mos	

Why would you like to become a family living provider?

What are the benefits of working with the biological family?

Work Experience
(beginning with most recent)

#1

Primary Provider		Alternate Provider
Occupation		
Employer		
Employer Address		
Typical Work Schedule		
yrs mos	Length of Employment	yrs mos
$	Monthly Take Home Pay	$
Job Description/Duties		
Reason for Leaving		

Work Experience (Continued)

#2

Primary Provider			Alternate Provider	
Occupation				
Employer				
Employer Address				
Typical Work Schedule				
yrs	mos	Length of Employment	yrs	mos
$		Monthly Take Home Pay	$	
Job Description/Duties				
Reason for Leaving				

#3

Primary Provider			Alternate Provider	
Occupation				
Employer				
Employer Address				
Typical Work Schedule				
yrs	mos	Length of Employment	yrs	mos
$		Monthly Take Home Pay	$	
Job Description/Duties				
Reason for Leaving				

Related Training/Volunteer Experiences

Please list any other schooling, experience, volunteer work, training, or certification which relates to the family living role including experience in the fields of Mental Health, Mental Retardation, Medical Care, Child Care, Physical Disability, or other Human Service Occupations

Primary Provider			Alternate Provider	

Health

Primary Provider			Alternate Provider	
		How would you describe your general physical health?		
☐ Yes	☐ No	Do you have a chronic health problem? If yes, please describe.	☐ Yes	☐ No
☐ Yes	☐ No	Are you free from contagious disease?	☐ Yes	☐ No
☐ Yes	☐ No	Have you been vaccinated for Hepatitis B?	☐ Yes	☐ No
		Mental health services received (counseling or inpatient services) with dates		
		Do you provide healthcare for a family or household member?		
☐ Yes	☐ No	Do you currently work for any division of RHD? If so, which division?	☐ Yes	☐ No
☐ Yes	☐ No	Have you ever worked for any division of RHD? If so, which division?	☐ Yes	☐ No

Description of Home and Neighborhood

Single ☐ Twin ☐ Townhouse ☐ Apartment ☐ Row Home ☐ Other ☐

Total # Rooms How long have you lived at the current address? years

bathrooms: # bedrooms: # floors: (including basement & attic)

Own ☐ Buying ☐ Renting ☐ Lease Expiration:

Do you have current Homeowner's or Renter's insurance? Yes ☐ No ☐

Is there currently a lien on your home? Yes ☐ No ☐

If yes, please explain:

If applicable, please describe your yard or available outdoor property:

Please describe your neighborhood:

How do you think your neighbors would react to a person with a disability living in your home?

Do you have any pets? Yes ☐ No ☐

What kind? How many?

Planned Occupancy – please indicate the names and other information of people who you expect to move into or out of the home (e.g., aging parent, student returning from school, family member returning from active duty)

First and Last Name	Age	Move In/Out	Expected Date	Needs In-Home Care
		In ☐ Out ☐		Yes ☐ No ☐
		In ☐ Out ☐		Yes ☐ No ☐
		In ☐ Out ☐		Yes ☐ No ☐
		In ☐ Out ☐		Yes ☐ No ☐

What would be the bedroom/sleeping arrangement for the person with disability living with you? (e.g., what floor of the home, share with anyone, etc)

Type of heating: If oil, when was the last time the heater was inspected?

Do you have a backup heating system?

If yes, please explain:

Home and Neighborhood (Continued)

Do you have a fireplace or wood-burning stove?

If yes, how often is it used? When was the chimney cleaned last?

Do you own ☐ or lease ☐ an automobile? No ☐

Do you have current car insurance? Yes ☐ No ☐ Expiration:

Are you willing to transport an individual to necessary appointments (including school or day program)? Yes ☐ No ☐

Is there public transportation available in the area? Yes ☐ No ☐

If yes, what type? How close?

Describe the volume of traffic on your road:

Are there sidewalks for pedestrians near your house? Yes ☐ No ☐

What is the name of the closest hospital?

How far is it from your home?

Do you have a support network (family/friends) that would be willing to provide back-up care for the person with disabilities who lives with you? Please describe, e.g., who, their relation to you, where they live, etc.

First and Last Name	Relationship	Address (City, State)

References

Are you now or have you ever in the past provided residential/foster care in your home for children or adults? Yes ☐ No ☐

If yes, please give dates, names of agencies, number and type of children/adults served:

Dates	Agency	Number	Type of Individual
-			
-			
-			

Will you allow RHD to get a letter of reference from the above agencies? Yes ☐ No ☐

Please submit 2 letters of reference from non-related personal or professional references. These letters should talk about your ability to be a Shared Living Provider.

Respite Provider Information

Please give the following information for anyone you would like to be a respite provider:

Name and Address	Phone Number	Relationship	Length of Time Known
	( ) -		years
	( ) -		years
	( ) -		years

Criminal History/Child Abuse Clearance

Were you or any other adult living in the home ever convicted of a criminal offense - including drug or alcohol related driving under the influence (DUI) anywhere (city, country, etc)

Primary: Yes ☐ No ☐ Alternate: Yes ☐ No ☐ Other adult(s): Yes ☐ No ☐

If yes, please give details on a separate sheet of paper and provide us with a copy of the docket.

Were you or any of the other adults living in the home psychiatrically hospitalized within the last ten years?

Primary: Yes ☐ No ☐ Alternate: Yes ☐ No ☐ Other adult(s): Yes ☐ No ☐

If yes, please give details on a separate sheet of paper.

Are you involved with any judicial proceedings and are there any criminal charges against you now pending? (Omit anything prior to your 18th birthday)

Primary: Yes ☐ No ☐ Alternate: Yes ☐ No ☐ Other adult(s): Yes ☐ No ☐

If yes, please give details on a separate sheet of paper.

Have you or any other adult living in the home had a Restraining Order issued against them?

Primary: Yes ☐ No ☐ Alternate: Yes ☐ No ☐ Other adult(s): Yes ☐ No ☐

If yes, please give details on a separate sheet of paper and provide us with a copy of the docket.

Were you or any other adults living in the home treated for Substance Abuse or Addictions in the last ten years?

Primary: Yes ☐ No ☐ Alternate: Yes ☐ No ☐ Other adult(s): Yes ☐ No ☐

If yes, please give details on a separate sheet of paper.

A Criminal History Clearance (or FBI Clearance for non-Pennsylvania residents) and a Child Abuse Clearance will be completed as a part of the application process.

Agreement

Please initial each line

_____ The information on this application is true to the best of my knowledge. I understand that any false statement or omission of material/fact may disqualify me from further consideration for becoming a family living provider.

_____ I understand that the information shared on this application is solely for the purposes of matching compatibility and determining eligibility as a family living provider.

_____ I understand that this application is not for agency employment purposes and is only for the purposes of a potential contract with the agency as a provider of family living services.

_____ I understand that completion of this application does not constitute an agreement for authorization to provide services in my home.

_____ I agree to allow a study and inspection to be made of my home to ascertain my qualifications and compliance with Family Living program requirements.

_____ I understand that the agency or the applicant can discontinue the application process at any time and for any reason.

_____ I agree to notify RHD/GROWTH if I am ever terminated or involved in an investigation with any agency at any point during my relationship with RHD/GROWTH

Primary Provider Signature	Date	Alternate Provider Signature	Date
Primary Provider Name (print)	Date	Alternate Provider Name (print)	Date

All information received on this application will be handled with the utmost care and confidentiality.