STATE OF MARYLAND
Department of Human Resources

Project Home

C.A.R.E. HOME PROVIDER APPLICATION

Personal Information: PLEASE PRINT

Provider Applicant's Name: ______________________________

Provider Street Address: ______________________________
(Street)

____
(City) (County) (State) (Zip)

Provider Applicant's telephone number: ______________________________
(Home) (Work) (Cell)

Provider E-mail Address: ______________________________

Provider Mailing Address: ______________________________
(Street)

____
(City) (County) (State) (Zip)

Telephone number of C.A.R.E. Home: ______________________________

Social Security #: ____________________ **Birth date:** ____________________

Gender: Female ☐ Male ☐

Place of Birth: ____________________ **Citizenship:** ____________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Race: ____________________

Financial/Employment Information:
Are you currently: Employed ☐ Not employed ☐ Retired ☐
Please complete below.

Applicant:
Occupation: ____________________
Employer: ____________________
Length of time: ____________________
Work Schedule: ____________________
Annual Salary: ____________________

Spouse/Significant Other:
Name: ____________________
Occupation: ____________________
Employer: ____________________
Length of time: ____________________
Work Schedule: ____________________
Annual Salary: ____________________

Other Income (rental, part-time jobs, boarder, retirement income):
(Source) (Amount)
____

List below ALL persons living in your household:

	Name	**DOB**	**Relationship to Care Provider**	**Social Security No.** If over 18 yrs. old
1.				
2.				
3.				
4.				
5.				
6.				

Please answer the following questions about your proposed home.

1. **Do you own** ☐ **or rent** ☐ **the house in which you live?**
2. **Do you live in the house in which you plan to provide Project HOME services?** ☐ Yes ☐ No
3. **How long have you lived in this house?**_______________________
4. **What is the amount of your monthly mortgage or rent?**_______________
5. **Are you currently providing care to adults or children in your home?** ☐ Yes ☐ No
6. **Have you ever provided care to an elderly or disabled adult in your home?** ☐ Yes ☐ No
7. **Are you currently licensed for Assisted Living by Department of Health and Mental Hygiene?** ☐ No ☐ Yes If yes, license #_______________
8. **Does your home have handicap or wheelchair accessibility?** ☐ Yes ☐ No

   If yes, please check all that applies below:

   ☐ **Ramp**

   ☐ **Lift**

   ☐ **Elevator**

   ☐ **Widened doorways**

   ☐ **Handicapped bathroom facilities**

9. **Do you have steps leading into your home?** ☐ Yes ☐ No **If yes, how many?** _________
10. **Does your home have a first floor bedroom?** ☐ Yes ☐ No
11. **Does your home have a bathroom on the first floor?** ☐ Yes ☐ No

12. **Do you have training related to the care of adult persons with physical or mental disabilities?**
☐ Yes ☐ No (If yes, please explain below – question #2)

13. **How did you learn about Project HOME?**

____

____

14. **Do you have a high school diploma or G.E.D.?** ☐ Yes ☐No

15. **Have you or has anyone in your household ever been arrested or convicted?** ☐ Yes ☐No

If yes, please explain

____

____

16. **Do you have any health problems that would limit the types of activities you would be able to perform?** ☐ Yes ☐ No

If yes, please explain

____

____

Please answer the following questions (use additional sheets if needed)

1. **Why do you want to become a Project HOME Provider?**

____

____

____

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2. **Describe below all your experience and/or training related to the care of elderly or mentally or physically disabled persons.**

____

____

____

3. **Project HOME clients require a level of supervision and care. How do you plan to meet your care-giving responsibilities if you work outside the home?** __

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____

____

____

4. **Project HOME Providers are responsible for escorting residents to doctors and other essential appointments. Do you drive and have access to a car or how do you plan to do this task?**

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____

5. **Training is a requirement for Project HOME Providers, and it is usually offered during the day. Will you be able to attend these trainings?** ____________________

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____

6. **What languages, if any, do you speak (including American Sign Language)?**

____

____

____

7. **Are there any cultural, spiritual or religious issues for you that would relate to client care?**

____

____

8. **Project HOME cannot guarantee placements. Can you document sufficient financial resources in the absence of Project HOME clients?** ____________________

____

PLEASE INDICATE BELOW YOUR CLIENT PREFERENCES

Age:	☐ **18-25**	☐ **26-40**	☐ **41-59**	☐ **60-79**	☐ **80 and over**
Sex:	☐ **Male and/or female**		☐ **Male only**	☐ **Female only**	
	☐ **Non-smoker**		☐ **Smoker (outdoors)**		☐ **Smoker**
	☐ **History of drug/alcohol abuse**				
	☐ **Mental Disability**				
	☐ **Physical Disability**				
	☐ **Advanced HIV/AIDS**				
	☐ **Asymptomatic HIV**				
	☐ **Incontinence**		☐ **Visually impaired**	☐ **Speech/hearing impaired**	
	☐ **Mobility impaired**		☐ **Wheelchair user**	☐ **Confused elderly**	

REFERENCES

Please list below three individual references that can answer questions about your qualifications as a caregiver (DO NOT USE RELATIVES). If you have been paid as a caregiver for disabled adults, one or two of these former/present employers must be included.

1. Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: ______________________________
Day Evening Cell

2. Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: ______________________________
Day Evening Cell

3. Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: ______________________________
Day Evening Cell

PLEASE CAREFULLY READ THE FOLLOWING PARAGRAPH BEFORE SIGNING THE APPLICATION BELOW:

(I) (We) hereby apply for certification of the home identified as a C.A.R.E. home. (I) (We) understand that a representative from the Department of Social Services may personally interview (me) (us) and other members of the household and may inspect this home. (I) (We) agree that any references, including relevant employers, may be contacted to assisted in establishing (my) (our) suitability as a C.A.R.E. home provider. (I) (We) further agree to allow the agency to request any arrest records and verification of any information listed on the application.

CONFIDENTIALITY:

When you care for a disabled adult, you will have access to personal information about the disabled adult. This information is shared with you so that you can better care for your client. The Code of Maryland Regulations (C.O.M.A.R. 07.01.02 and 07.01.07) states that any information you are given, whether verbally or in writing, is to be kept confidential. A violation of confidentially is a misdemeanor, and is subject to a fine, imprisonment, or both. For your protection, if you have any questions about the release of any information, discuss them with your client's case manager.

______________________________ ______________

Signature of Prospective Provider **Date**

______________________________ ______________

Spouse/Significant Other Signature **Date**

***PROVIDING FALSE OR INCOMPLETE INFORMATION ON THIS FORM MAY BE CAUSE FOR REJECTING THE APPLICATION.**

Mail Application to: