

**Community Services Contract Application – Addendum B  
Adult Foster Care Provider Questionnaire**

<b>Please Complete and Return To:</b>	Mailed	Rec'd. (DADS Use)
Name	Telephone No.	
Address		

**Each question must be answered fully before the application can be accepted.**

**Section 1. Identifying Information**

Applicant's Name (Last, First, Middle)	Social Security No.
Spouse's Name	Social Security No.
Mailing Address (Street or P.O. Box, City, State, ZIP)	
Home Address (if different)	Telephone No.

**Directions to Home:**

**Section 2. Information About Applicant**

Health Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Describe any significant health problems or disabilities:		
Date of Birth	Religious Preference	Ethnic Group <input type="checkbox"/> Anglo <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (specify):	
Primary Language	Other Languages Spoken	Education <input type="checkbox"/> Grammar School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> College Degree	
Employer			Work Telephone
Employer's Address			
Working Hours	How Long Employed	Salary	
Annual Earnings <input type="checkbox"/> Less than \$5,000 <input type="checkbox"/> \$5,000 - \$9,999 <input type="checkbox"/> \$10,000 - \$14,999 <input type="checkbox"/> \$15,000 - \$19,999 <input type="checkbox"/> \$20,000 - \$24,999 <input type="checkbox"/> \$25,000 or more			
Other Monthly Income (list source)			▶ Net Amount

**Interests and Hobbies:**

**Section 3. Information About Spouse**

Health Status <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Describe any significant health problems or disabilities:	
Date of Birth	Religious Preference	Ethnic Group <input type="checkbox"/> Anglo <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (specify):	
Primary Language	Other Languages Spoken	Education <input type="checkbox"/> Grammar School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> College Degree	
Employer		Work Telephone	
Employer's Address			
Working Hours		How Long Employed	Salary
Annual Earnings <input type="checkbox"/> Less than \$5,000 <input type="checkbox"/> \$5,000 - \$9,999 <input type="checkbox"/> \$10,000 - \$14,999 <input type="checkbox"/> \$15,000 - \$19,999 <input type="checkbox"/> \$20,000 - \$24,999 <input type="checkbox"/> \$25,000 or more			
Other Monthly Income (list source)		▶ Net Amount	

**Interests and Hobbies:**

**Section 4. Household Information**

Names of Household Members (other than provider and spouse)	Relationship	Age	Sex	School Grade or Occupation	Health		
					Good	Fair	Poor
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

Others Living in Household (periodically or temporarily)	Relationship	Age	Sex	School Grade or Occupation	Health		
					Good	Fair	Poor
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  

Others Employed to Work in Your Home	Relationship	Age	Sex	School Grade or Occupation	Health		
					Good	Fair	Poor
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 5. Health Information**

Describe any illnesses, disabilities, chronic conditions or nervous problems that any member of your household has or has had. (Describe who, when, give dates; describe medical treatment and/or counseling.)

Are you currently taking any medication? .....  Yes  No

If Yes, describe:

Have you or any member of your household ever received any treatment for emotional problems? .....  Yes  No

If Yes, describe:

Would you consent to a report by the agency that is providing any treatment for emotional problems? .....  Yes  No

If No, why not?

Have you had a medical examination within the last year? .....  Yes  No

If Yes, please provide the following information:

Physician's Name	Address	Telephone No.
Findings:		

If No, can you get a medical examination before admitting the first consumer? .....  Yes  No

**Section 6. Information About the Home**

Type of Home <input type="checkbox"/> Single Family Dwelling	Multiple Family Dwelling <input type="checkbox"/> (apartment, duplex)	Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other (describe):	No. of Floors
Buying or Renting <input type="checkbox"/> Buying <input type="checkbox"/> Renting	What safety features are in your home? <input type="checkbox"/> Smoke Detectors <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Grab Bars <input type="checkbox"/> Nonslip Mats <input type="checkbox"/> Fencing <input type="checkbox"/> Ramps <input type="checkbox"/> Outside Fire Escape <input type="checkbox"/> Other (explain):		

Is there anything hazardous about your home or yard (heavy equipment, canal, drainage ditch, swimming pool)? .....  Yes  No

If Yes, explain:

Is your home on or close to a city bus route? .....  Yes  No

What transportation are you willing to provide for consumers (church, shopping, doctor, etc.)? Please specify.

Describe your neighborhood (families with young children, retired people, young singles, apartments, businesses, neat, in need of repair, receptiveness to people with disabilities).

Do you have homeowner's insurance to provide liability coverage for accidents/injuries involving nonfamily members that may occur on your property?.....  Yes  No

Is your homeowner's insurance valid when your house is used as a foster home? .....  Yes  No

Does your motor vehicle insurance provide liability coverage for nonfamily member passengers? .....  Yes  No

**Section 7. Home Environment and Family Attitudes**

Have you and your spouse discussed becoming providers?.....  Yes  No

Have you and your spouse discussed becoming providers with other family members living in your home? .....  Yes  No

Do you expect any problems in household members' ability to get along with an unrelated person living in the home?  Yes  No

What type of problems do you expect with your friends and your children's friends in getting along with and accepting any unrelated persons living in the home?

Would a consumer's religious preference that is different from yours create a problem for you and your family? .....  Yes  No

Do you allow alcoholic beverages to be used in your home?.....  Yes  No

Do you allow smoking in your home?.....  Yes  No

How do you and your family spend your leisure time?

List the kinds of pets you have and describe their temperaments.

How do you and each of your family members show affection (freely, sparingly, by touching, joking, kidding)?

How are decisions made and problems solved within your household?

Explain briefly why you would like to be a foster home provider.

Describe your life experiences and/or special training that would be helpful in caring for elderly or disabled consumers.

Have you or any household member been convicted within the last 10 years of a felony classified as an offense against the person or family or as public indecency, or of a violation of the Texas Controlled Substances Act, or of any misdemeanor classified as an offense against the person or family or as public indecency? (This information must be given for anyone residing in the home or providing care to consumers.).....  Yes  No

If Yes, describe:

How many elderly or disabled consumers do you want to care for? .....

Age range desired.....

Which do you prefer to live in your home? .....  Male  Female  Either  Both

Describe the type of person you would like to have live with you.

Would you be willing to care for an elderly or disabled person with behavior problems? .....  Yes  No

What experience have you had in dealing with this type of person?

Are there any consumers with certain behavioral problems that you would not take?

**Section 8. References**

List three non-related persons who have known you for more than one year that the department can contact.

Name	Address (Street, City, State, ZIP)	Telephone No.	How Long Known

List two references the department can contact in case of an emergency.

Name	Address (Street, City, State, ZIP)	Telephone No.	How Long Known

Have you provided foster care before or ever applied to provide foster care? .....  Yes  No

If Yes:

What agency?	When?
Address of Agency	

Who referred you to the Department of Aging and Disability Services? \_\_\_\_\_

How did you hear about this program?

Radio  Television  Newspaper  Word of Mouth  Other (explain): \_\_\_\_\_

**AFFIDAVIT – I hereby certify that this application contains no willful misrepresentation or falsification and that the information given by me is true and correct to the best of my knowledge and belief. I understand that should an investigation disclose any such misrepresentation or falsification, my application for a contract to be an individual service provider will be rejected.**

  

_____	_____
Signature – Applicant	Date
_____	_____
Signature – Spouse	Date