Washington State Department of Social & Health Services
Transforming lives

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Adult Family Home
Caregiving Experience Attestation (CEA)

Why must this CEA form be completed?

Washington state law (RCW 70.128.120) specifies the minimum qualifications for Adult Family Home (AFH) providers, individual applicants, spouse co-provider or state registered domestic partner co-provider, entity representatives, and resident managers. Subsection (9) of the law states: For those applying to be licensed as providers, and for resident managers whose employment begins after August 24, 2011, at least one thousand hours in the previous sixty months of successful, direct caregiving experience obtained after age eighteen to vulnerable adults in a licensed or contracted setting prior to operating or managing an adult family home. The individual applicant, spouse co-provider or state registered domestic partner co-provider, entity representative or resident manager must have credible evidence of the successful, direct caregiving experience.

If you have one of the following valid, current professional licenses, you **DO NOT** have to complete this form:

Physician, Osteopathic physician licensed under Chapter 18.71 RCW, Physician Assistant, Osteopathic physician assistant licensed under Chapter 18-57A RCW, or RN, ARNP, or LPN licensed under Chapter 18.79 RCW. This requirement is pursuant to WAC 388-76-10065, and WAC 388-76-10130.

Who must complete this CEA form?

The attestor who completes the form must have personal knowledge of the direct caregiving experience achieved after age eighteen. The attestor on this form may be a supervisor, co-worker, client / resident or a family member of a client/resident. Aging and Long-Term Support Administration and Developmental Disabilities Administration case managers cannot serve as attestors. A completed CEA Form, with a notarized signature, is the only acceptable documentation that meets this requirement. The department may request additional caregiving experience attestations.

If applying for an Adult Family Home License, please submit this form with the Adult Family Home License Application.

The department will NOT accept the attestation if incomplete and/or not notarized.

Section 1. Completed by provider, individual applicant, spouse co-provider, or State Registered Domestic Partner (SRDP) co-provider, entity representative, or resident manager.

Check here to indicate whether you are a:

☐ Applicant / Provider ☐ Spouse / SRDP Co-Provider ☐ Entity Representative ☐ Resident Manager

1. INDIVIDUAL APPLICANT'S / CO-PROVIDER'S / ENTITY REPRESENTATIVE'S / RESIDENT MANAGER'S NAME			
2. NAME OF ADULT FAMILY HOME			
3. ADDRESS OF PROPOSED ADULT FAMILY HOME	CITY	STATE	ZIP CODE

Section 2. This section is to be completed by the attestor.

Write N/A (not applicable) for areas that do not apply.

1. YOUR NAME	TITLE OR ROLE

2. Provide two telephone numbers where you can be reached between 8:00 a.m. and 5 p.m. weekdays.

TELEPHONE NUMBER (INCLUDE AREA CODE)	ALTERNATE TELEPHONE NUMBER (INCLUDE AREA CODE)

3. What is the best time to call during those hours?
4. How do you know the person named in Section 1? ☐ Co-worker ☐ Employer / Superior ☐ Client / Resident ☐ Family member of client / resident ☐ Other (only upon department approval):
5. Does this person currently work for you? ☐ Yes ☐ No
6. In what care setting (licensed or contracted) did you work with him / her?
7. What is the name of the place where you work / worked with this person?
8. Did this person's primary responsibilities include providing direct care and assistance to vulnerable adults? ☐ Yes ☐ No; if no, what other duties?
9. Did this person's total hours of direct care experience exceed 1,000 hours? ☐ Yes ☐ No
   If no, how many hours? Dates (month and year): From: To:
10. List the dates the care was provided (month and year): From: To:
11. Did this person meet the physical and emotional needs of care recipients? ☐ Yes ☐ No
12. Was the person reliable: ☐ Yes ☐ No
13. Did this person have the ability to follow procedures, guidelines, and instructions? ☐ Yes ☐ No
14. Was the person an employee, why did the person leave?
    If not an employee, check here: ☐ N/A
15. Would you employ this person to be a caregiver for vulnerable adults? ☐ Yes ☐ No
    If no, why not?

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE

NOTARY PUBLIC

State of _____ County of _____

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me, and said person acknowledged that he / she signed this instrument and acknowledged it to be his / her free and voluntary act for the uses and purposes mentioned in the instrument.

_____

Dated: _____

(Seal or Stamp)

_____
SIGNATURE

Title: _____

My appointment expires: