

# Adult Family Home License Application

Review the [Resource / Instructions](#) document when completing this application.

Section 1. Type of Application				
<input type="checkbox"/> <b>Initial</b> (application fee \$2750) <input type="checkbox"/> <b>Change of Ownership</b> (application fee \$700) <input type="checkbox"/> <b>Relocation Only</b> (application fee \$2750) <ul style="list-style-type: none"> <li>• Current AFH address: _____</li> <li>• Current AFH license number: _____</li> </ul>				
Section 2. Proposed Adult Family Home Information				
NAME OF PROPOSED ADULT FAMILY HOME				
STREET ADDRESS		CITY	STATE	ZIP CODE COUNTY
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY	STATE	ZIP CODE
FACILITY TELEPHONE NUMBER		FAX NUMBER		
CELL PHONE NUMBER		EMAIL ADDRESS REQUIRED		
Section 3. Property Owner(s) Information				
Will the property owner(s) take an active interest in the operation of the Adult Family Home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
PROPERTY OWNER(S) NAME(S)				
PROPERTY OWNER(S) PHYSICAL ADDRESS (NO P.O. BOX)		CITY	STATE	ZIP CODE
Section 4. Federal Employer Identification Number (EIN)				
2. APPLICANT'S EIN NUMBER				
Section 5. Legal Entity Information (Legal Business Name) <b>Sole Proprietor, Skip to Section 7.</b>				
Complete this section <u>only</u> if the business is a corporation, partnership, limited liability company (LLC), non-profit or other entity.				
1. LEGAL NAME OF ENTITY		2. TELEPHONE NUMBER	3. FAX NUMBER	
4. MAILING ADDRESS		CITY	STATE	ZIP CODE
Section 6. Individuals Affiliated with Legal Entity				
List all partners, owners, officers, directors or members of the legal entity and any percentage of ownership for each individual if applicable. If more space is needed attach additional page to the application				
NAME OF PERSON	TITLE OR POSITION	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	PERCENT OWNERSHIP
				%
				%
				%
				%
				%

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## Section 7. Sole Proprietor or Entity Representative Information

1. NAME OF SOLE PROPRIETOR OR ENTITY REPRESENTATIVE (LAST, FIRST, MIDDLE)

## Section 8. Married Couple or State Registered Domestic Partner Information (Sole Proprietor's Only)

As a sole proprietor, are you applying as a married couple or SRDP to be licensed together?  Yes  No

2. NAME OF SPOUSE OR SRDP (LAST, FIRST, MIDDLE)

## Section 9. Resident Manager Information

1. NAME OF RESIDENT MANAGER (LAST, FIRST, MIDDLE)

## Section 10. Specialty Training

Check all that apply:

- I do not intend to admit and care for residents with dementia, mental illness and/or developmental disabilities
- I intend to admit and care for residents with dementia, mental illness and/or developmental disabilities. I have submitted certificates for the following:
- Manager Dementia Specialty Training
  - Manager Mental Health Specialty Training
  - Developmental Disability Specialty Training

## Section 11. Licensing, Contracting and Certification History

1. Has any person or entity named in this application ever held a license for a business providing services to vulnerable adults, children, or persons with mental illnesses or developmental disabilities?
- Yes  No

**If yes, complete the following information. If you need more space, attach additional page to application.**

- Name of the individual: \_\_\_\_\_
- Type of license: \_\_\_\_\_
- Name and address of facility: \_\_\_\_\_

2. Has any person or entity named in this application ever held a Medicaid or other social services contract to provide services to vulnerable adults, children or persons with mental illnesses or developmental disabilities? This includes Individual Provider contract.
- Yes  No

**If yes, complete the following information. If you need more space, attach additional page to application.**

- Name of person or entity: \_\_\_\_\_
- Type of contract: \_\_\_\_\_

3. Has any person or entity named in this application ever had a founded finding and/or conviction of abuse, neglect, exploitation, or misappropriation of property by a professional licensing agency, a state licensing or contracting agency, Child Protective Services, Adult Protective Services, or court?
- Yes  No

**If yes, complete the following information. If you need more space, attach additional page to application.**

- Name of person or entity: \_\_\_\_\_
- Type of finding and/or conviction: \_\_\_\_\_

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4. Has any person or entity named in this application ever been denied a license, contract, or certification to operate a facility providing care to vulnerable adults, children or persons with mental illnesses or developmental disabilities?  
 Yes    No

**If yes, complete the following information. If you need more space, attach additional page to a application.**

- Name of person or entity: \_\_\_\_\_
- Type of type of license, contract, or certification: \_\_\_\_\_

5. Has any person or entity named in this application been licensed, contracted, or certified to provide care or services to vulnerable adults or children,  Yes    No; and:

- a. Was the license or certification revoked, suspended, suspended with stay, enjoined, or imposed with conditions, civil fine or stop placement?  
 Yes    No

- b. Was the Medicaid contract or Medicare provider agreement revoked, cancelled, suspended, or not renewed?  
 Yes    No

- c. Relinquished such license / certification or did not seek the renewal when notified by the state agency of initiation of denial, suspension, cancellation, or revocation?  
 Yes    No

**If yes to any question above, complete the following information. If you need more space, attach additional page to application.**

- Name of the individual: \_\_\_\_\_
- Type of license, certification or contract: \_\_\_\_\_
- Name and address of facility: \_\_\_\_\_
- Date of action: \_\_\_\_\_

### Section 12. Background Information

Complete an on-line background authorization form located at <https://fortress.wa.gov/dshs/bcs/>. **Print and submit the completed background authorization form that contains the confirmation code located in the upper right hand corner for each of the following:**

- Sole Proprietor or Entity Representative
- Spouse or State Registered Domestic Partner of Sole Proprietor
- Entity Owners, Partners, Officers, Directors (includes all members of corporation)
- Resident Manager
- Any person(s) who will live in the Adult Family Home.

Do not include residents or any person under the age of 11.

NAME OF PERSONS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	ROLE IN AFH (N/A IF NONE)

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## Section 13. Current Employee of the State of Washington

1. Are you currently employed by the Department of Social and Health Services (DSHS)?

Yes  No

**If yes, please list the name of the individual(s) and department(s):**

a. Does the employment involve authorizing payments or involve placement for any resident's care and services in an Adult Family home?

Yes  No

2. Are you or any household member currently employed by Aging and Long-Term Support Administration (AL TSA)?

Yes  No

## Section 14. Consent to Release and/or Use Confidential Information

All persons named in this application must read Section 12 and sign below.

I consent to the release and use of confidential information about me within (DSHS) for purposes of licensing. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose information to other parts of the department as appropriate. The department may define some or all of such information as public information and also disclose this information to third parties when requested according to law to the extent that such information is not exempt from such disclosure by state or federal law. Information may be shared verbally or by computer, mail, or hand delivery.

I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. ([RCW 42.56](#), Chapter [388-01 WAC](#))

I understand that the Department may obtain a credit report of the sole proprietor, entity representative, spouse or state registered domestic partner, entity owners, partners, officers, members and directors of corporation; to determine financial solvency.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

NAME OF INDIVIDUAL (PLEASE PRINT)	SIGNATURE	DATE
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## Section 15. Applicant Certification Signature

I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for licensure of an adult family home are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.

I certify that the applicant, spouse co-applicant, or State Registered Domestic Partner co-applicant, entity representative, and resident manager are at least 21 years of age or older.

Copies of all documents needed to verify the items in this application are attached, and original documents will be readily available for the licensuror.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, termination of a license, or other sanctions as allowed by [WAC 388-76-10125](#).

I understand and agree that the information I give to the department will be used to verify the information in this application. Any information given to the department may be used by the department for this purpose.

I understand that the department will perform an individual credit history check for all applicants per [RCW 70.128.120](#). I understand that if my application for an adult family home license is denied, I may request an administrative fair hearing within 28 days of receiving the denial letter from DSHS.

I have read RCW Chapters [70.128](#), [70.129](#), [74.34](#), and WAC [388-76](#), [388-112A](#), and [388-110](#) and any other applicable laws and rules.

### Notice to Applicant

The [Resource / Instructions](#) document outlines all required documents. An Adult Family Home (AFH) application becomes void if the applicant does not return information within 60 calendar days of first request or has not obtained the license within one calendar year of submitted date per [\(WAC\) 388-76-10075](#).

The Department of Social and Health Services (DSHS) issues an adult family home license to individuals and entities to provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services ([RCW 70.128.010](#)). No individual or entity shall operate or maintain an adult family home in this state without a license ([RCW 70.128.050](#)).

The adult family home license is issued to the licensee (operator) and is not transferable [WAC 388-76-10010\(3\)\(a\)](#).

The licensee/operator is ultimately responsible for the daily operational decisions of the adult family home and the care of residents ([WAC 388-76-10015](#)). If/when I am licensed:

- I understand that any resident manager I employ must meet the requirements of [RCW 70.128.120](#) and [WAC 388-76-10130](#).
- No residents receiving care and services in the adult family home will be subject to discrimination on the basis of race, color, national origin, gender, age, religion, creed, marital status, disabled or Vietnam veteran's status, or the presence of any physical, mental, or sensory disability.
- If any residents need delegated care, I will make sure that the care is delegated by a registered nurse according to state law and rules.
- I will use the approved floor plan and will not change the use of any room until the local building inspector, if required, and the Residential Care Services field office have reviewed and approved the changes.

I will not exceed the approved capacity of the adult family home, and will contact the Residential Care Services field office before making any capacity changes.

## Section 15. Applicant Certification Signature

SIGNATURE OF SOLE PROPRIETOR OR ENTITY REPRESENTATIVE

DATE

PRINT NAME

## Section 16. Spouse Co-Provider / SRDP Certification Signature

SIGNATURE OF CO-APPLICANT (SPOUSE OR STATE REGISTERED DOMESTIC PARTNER)

DATE

PRINT NAME