



Adult Family Home Caregiving Experience Attestation (CEA) Form A For Applicants for Licensure

Instructions

Why must this CEA form be completed?

Washington state law (RCW 70.128.120(9)) specifies the minimum qualifications for adult family home (AFH) providers and resident managers. One of the qualifications is that the provider and resident manager must have at least one thousand hours in the past 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.

Residential Care Services requires caregiving experience information about each individual applicant, spouse co-provider or state registered domestic partner co-provider, entity representative and resident manager who will have responsibility for the daily operations of the adult family home. The information is used to determine whether the individual has had successful, direct caregiving experience. Direct caregiving experience is defined as having responsibility for the caregiving of vulnerable adults and assuring that their personal or special care needs were met.

This requirement is pursuant to RCW 70,128,120(9), RCW 70.128.060(2), WAC 388-76-10065, and WAC 388-76-10130. A completed CEA Form A, with a notarized signature, is the only acceptable documentation that meets this requirement. The department may request additional caregiving experience attestations. Failure to provide the required information may result in a denial of an AFH license.

The attestor must mail the completed CEA form to Residential Care Services, ATTN: BAAU, PO Box 45600 Olympia WA 98504-5600.

The department will not accept the attestation if it is not complete and not notarized. The department will not accept the attestation if it is mailed in with the adult family home license application.

For Whom Must this form be completed?

The attached CEA form must be completed for each individual applicant, spouse co-provider or state registered domestic co-provider, entity representative and resident manager.

When must this CEA form be completed?

An application will not be considered complete without a correctly completed CEA form(s) totaling the required 1,000 hours in the past sixty months of successful direct caregiving to vulnerable adults, for each person who must meet this requirement.

Who must complete this CEA form?

The attestor who completes the form must have personal knowledge of the applicant's caregiving experience that has been achieved after age eighteen. Personal knowledge means that the attestor has actually observed care provided by the applicant. The attestor may include a former supervisor, a co-worker, a client/resident or a family member of a client/resident. AL TSA and DDA case managers cannot serve as attestors. The caregiving experience must have been provided to vulnerable adults in a licensed or contracted setting (for example, an adult family home, assisted living facility, nursing home, from an applicant who has a contract with a recognized social services agency to provide care to vulnerable adults in the past sixty months). The department does not accept attestations from family members of the individual applicant, spouse co-provider, or state registered domestic partner co-provider, entity representative, or resident manager.

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

Physician licensed under Chapter 18.71 RCW, Osteopathic physician licensed under Chapter 18.57 RCW, Osteopathic physician assistant licensed under Chapter 18-57A RCW, Physician Assistant licensed under Chapter 18.71A RCW, or RN, ARNP, or LPN licensed under Chapter 18.79 RCW.



AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)

Adult Family Home Caregiving Experience Attestation (CEA) Form A For Applicants for Licensure

Section 1. This section is to be completed by the proposed provider, spouse co-provider, or State Registered Domestic Partner (SRDP) co-provider, entity representative, or resident manager.

Check here to indicate whether you are a:

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

1. INDIVIDUAL APPLICANT/CO-PROVIDER'S/ENTITY REPRESENTATIVE'S/RESIDENT MANAGER'S NAME

2. NAME OF PROPOSED ADULT FAMILY HOME	3. COUNTY WHERE PROPOSED ADULT FAMILY HOME IS / WILL BE LOCATED
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4. ADDRESS OF PROPOSED ADULT FAMILY HOME	CITY	STATE	ZIP CODE
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Section 2. This section is to be completed by the attestor.

All information in this section must be provided by the attestor based upon his/her personal knowledge (supervised/observed) of care provided in a licensed or contracted working environment.

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

1. YOUR NAME	TITLE OR ROLE
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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)
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3. What is the best time to call during those hours?

4. How do you know the person named above in Section 1, Item 1? I am/was this person's:

- 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 did you work with him/her?

7. What is the name of the place where you work/worked with this person?

8. Did you personally observe this person providing care to a vulnerable adult? Yes No

9. Did this person's primary responsibilities include providing direct care and assistance to vulnerable adults?

- Yes No

If no, what other duties?

10. Did this person's total hours of direct care experience exceed 1,000 hours? Yes No

If no, how many hours? Dates: From: To:

11. Was this care in the past 60 months? Yes No Dates: From: To:

Please rate the applicant in the following areas:

12. Ability to meet the physical and emotional needs of care recipients:

Poor Below Average Average Above Average Excellent

Describe needs and tasks:

13. Reliability and integrity:

Poor Below Average Average Above Average Excellent

14. Ability to follow procedures, guidelines, and instructions:

Poor Below Average Average Above Average Excellent

15. Describe any special skills/knowledge the applicant demonstrated in the performance of his/her duties:

16. Describe any areas where improvement was needed with the applicant's caregiving:

17. If the applicant was an employee, why did the applicant leave?

If not an employee, check here N/A

18. 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 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: