Medical Foster Home Program
Caregiver Application

I. CAREGIVER INFORMATION

PRINT
LEGAL NAME _____
Last First MI

Any other names used: _____

Mailing Address _____
Number Street Apt Number

_____
City State Country Zip Code

Home Phone ( ) _____ Cell Phone ( ) _____

E-mail _____

DOB _____ Fax ( ) _____

Do you own ___ or rent ___ the home identified above? Do you live in this home? _____Yes _____No

Do you own pets? Type/Breed _____ how many _____ Rabies shots update_____

Do you smoke? ____ Yes _____No Would you allow smokers in your house? _____Yes _____No

Do you have a State License? _____Yes _____No (If yes, type of license? _____

Foster Home (Children) ____Assisted living ____Family/Adult Care Home _____Other_____

Date on license: _____ License Renewal Date_____

Circle Highest Education Level Attended/Completed: 6 7 8 9 10 11 12 13 14

Do you have a valid Driver's License? _____YES _____NO STATE: _____

Driver's License #:_____

List any language (s) you SPEAK, other than English: _____

List any language (s) you WRITE, other than English: _____

Check only one:
Are you a U.S. Citizen: _____YES _____NO?

Alien authorized to work in the United States? ____YES _____NO

II. OTHER HOUSEHOLD MEMBERS (use separate sheet if necessary)

Full Name	Date of Birth	Relationship to Provider
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
(4) _____	_____	_____

III. DESIGNATED RELIEF PERSON (S)

_____

Relief Person's Full Name

_____

Street Address City County Zip Telephone #

_____

Relief Person's Full Name

_____

Street Address City County Zip Telephone #

IV EMPLOYMENT HISTORY INFORMATION

Name and Mailing Address (City, State, etc.) of Company:	Dates Employed (Month and Year) From: To:	Hours Worked per week:
Your Job Title:	Name and Title of Supervisor	
Describe Your Work in Detail:		
Reason for Leaving:		

Name and Mailing Address (City, State, etc.) of Company:	Dates Employed (Month and Year) From: To:	Hours Worked per week:
Your Job Title:	Name and Title of Supervisor	

Describe Your Work in Detail:
Reason for Leaving:

Name and Mailing Address (City, State, etc.) of Company:	Dates Employed (Month and Year) From: To:	Hours Worked per week:
Your Job Title:	Name and Title of Supervisor	
Describe Your Work in Detail:		

V. REFERENCES		
A. NAME	B. ADDRESS	C. TELEPHONE NUMBER
Professional		
Professional		
Personal		
Neighbor		

Brief Description of your interest in caring for Veterans. Include what you have to offer as a caregiver to the program. What qualities do you have that would make you a good caregiver?

_____
_____
_____
_____
_____
_____
_____
_____

CERTIFICATION: I hereby certify that the statements in this application are true and correct, and recognize that failing to meet my responsibilities under this certification, or providing false information may result in denial or suspension of my participation in the Medical Foster Home Program.

I authorize Medical Foster Home Program staff to investigate the truthfulness of all statements made on this application and to contact my former employers and other listed references.

I give my consent for all contacted persons, including former employers, to provide information concerning this application. I release each person from liability for providing such information. I waive all causes of action that might arise from the foregoing. I understand that completing this application and initiating the certification process does not indicate that my home will be certified as a MFH. I further understand that the VA can decide at any point prior to certification not to proceed with certification of my home.

In making this application, and in the event that my home is approved by VA as a Medical Foster Home I agree to:

a. An initial inspection of my home by a health care team from VA facility and an annual inspection thereafter.
b. Authorize VA to contact other agencies regarding the suitability of my home for residential care.
c. Comply with VA standards for Residential Care and Medical Foster Home.
d. Accept Veterans without discrimination on the basis of race, color, sex, age, religion or national origin.
e. Accept the agreed-upon monthly rate as full compensation for care given.

I acknowledge that the ORIGINAL APPLICATION FORM AND APPROPRIATE SUPPLEMENTAL FORMS MUST BE SIGNED in order to be processed or evaluated.

I UNDERSTAND THAT SUBMITTING THIS APPLICATION DOES NOT GUARANTEE PARTICIPATION IN THE MFH PROGRAM

IF ACCEPTED IN THE MFH PROGRAM I AM NOT GUARANTEED PLACEMENTS OF VETERANS IN MY HOME

Legal Name Signature _____ Date _____