

**STATE OF MARYLAND**  
**Department of Human Resources**  
**Project Home**  
**C.A.R.E. HOME PROVIDER APPLICATION**

**Personal Information: PLEASE PRINT**

**Provider Applicant's Name:** \_\_\_\_\_

**Provider Street Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

**Provider Applicant's telephone number:** \_\_\_\_\_  
(Home) (Work) (Cell)

**Provider E-mail Address:** \_\_\_\_\_

**Provider Mailing Address:** \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

**Telephone number of C.A.R.E. Home:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Gender:** Female  Male

**Place of Birth:** \_\_\_\_\_ **Citizenship:** \_\_\_\_\_

**Marital Status:** Single  Married  Divorced  Widowed

**Race:** \_\_\_\_\_

**Financial/Employment Information:**

**Are you currently:** Employed  Not employed  Retired

Please complete below.

**Applicant:**  
**Occupation:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Length of time:** \_\_\_\_\_  
**Work Schedule:** \_\_\_\_\_  
**Annual Salary:** \_\_\_\_\_

**Spouse/Significant Other:**  
**Name:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Length of time:** \_\_\_\_\_  
**Work Schedule:** \_\_\_\_\_  
**Annual Salary:** \_\_\_\_\_

\_\_\_\_\_

Other Income (rental, part-time jobs, boarder, retirement income):

(Source)

(Amount)

DHR-PH-1304 Revised (Jan-16)

List below ALL persons living in your household:

	<u>Name</u>	<u>DOB</u>	<u>Relationship to Care Provider</u>	<u>Social Security No.</u> If over 18 yrs. old
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

Please answer the following questions about your proposed home.

1. Do you own  or rent  the house in which you live?
2. Do you live in the house in which you plan to provide Project HOME services?  Yes  No
3. How long have you lived in this house? \_\_\_\_\_
4. What is the amount of your monthly mortgage or rent? \_\_\_\_\_
5. Are you currently providing care to adults or children in your home?  Yes  No
6. Have you ever provided care to an elderly or disabled adult in your home?  Yes  No
7. Are you currently licensed for Assisted Living by Department of Health and Mental Hygiene?  
 No  Yes If yes, license # \_\_\_\_\_
8. Does your home have handicap or wheelchair accessibility?  Yes  No

If yes, please check all that applies below:

Ramp

Lift

Elevator

Widened doorways

Handicapped bathroom facilities

9. Do you have steps leading into your home?  Yes  No If yes, how many? \_\_\_\_\_

10. Does your home have a first floor bedroom?  Yes  No

11. Does your home have a bathroom on the first floor?  Yes  No

12. Do you have training related to the care of adult persons with physical or mental disabilities?

Yes  No (If yes, please explain below - question #2)

13. How did you learn about Project HOME?

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14. Do you have a high school diploma or G.E.D.?  Yes  No

15. Have you or has anyone in your household ever been arrested or convicted?  Yes  No

If yes, please explain

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16. Do you have any health problems that would limit the types of activities you would be able to perform?  Yes  No

If yes, please explain

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Please answer the following questions (use additional sheets if needed)

1. Why do you want to become a Project HOME Provider?

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2. Describe below all your experience and/or training related to the care of elderly or mentally or physically disabled persons.

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3. Project HOME clients require a level of supervision and care. How do you plan to meet your care-giving responsibilities if you work outside the home? \_\_\_\_\_

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4. Project HOME Providers are responsible for escorting residents to doctors and other essential appointments. Do you drive and have access to a car or how do you plan to do this task?

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5. Training is a requirement for Project HOME Providers, and it is usually offered during the day. Will you be able to attend these training sessions? \_\_\_\_\_

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6. What languages, if any, do you speak (including American Sign Language)?

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7. Are there any cultural, spiritual or religious issues for you that would relate to client care?

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8. Project HOME cannot guarantee placements. Can you document sufficient financial resources in the absence of Project HOME clients? \_\_\_\_\_

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**PLEASE INDICATE BELOW YOUR CLIENT PREFERENCES**

- Age:**    18-25         26-40         41-59         60-79         80 and over
- Sex:**    Male and/or female         Male only         Female only
- Non-smoker         Smoker (outdoors)         Smoker
- History of drug/alcohol abuse
- Mental Disability
- Physical Disability
- Advanced HIV/AIDS
- Asymptomatic HIV
- Incontinence         Visually impaired         Speech/hearing impaired
- Mobility impaired         Wheelchair user         Confused elderly



**PLEASE CAREFULLY READ THE FOLLOWING PARAGRAPH BEFORE SIGNING THE APPLICATION BELOW:**

**(I) (We) hereby apply for certification of the home identified as a C.A.R.E. home. (I) (We) understand that a representative from the Department of Social Services may personally interview (me) (us) and other members of the household and may inspect this home. (I) (We) agree that any references, including relevant employers, may be contacted to assisted in establishing (my) (our) suitability as a C.A.R.E. home provider. (I) (We) further agree to allow the agency to request any arrest records and verification of any information listed on the application.**

**CONFIDENTIALITY:**

**When you care for a disabled adult, you will have access to personal information about the disabled adult. This information is shared with you so that you can better care for your client. The Code of Maryland Regulations (C.O.M.A.R. 07.01.02 and 07.01.07) states that any information you are given, whether verbally or in writing, is to be kept confidential. A violation of confidentiality is a misdemeanor, and is subject to a fine, imprisonment, or both. For your protection, if you have any questions about the release of any information, discuss them with your client's case manager.**

\_\_\_\_\_  
**Signature of Prospective Provider**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Spouse/Significant Other Signature**

\_\_\_\_\_  
**Date**

**\*PROVIDING FALSE OR INCOMPLETE INFORMATION ON THIS FORM MAY BE CAUSE FOR REJECTING THE APPLICATION.**

**Mail Application to:**