Ohio Mental Health and Addiction Services
Application for Licensure as an Adult Foster Home (AFoH)

Instructions: This application is to be filled out by the operator and submitted along with the requested documentation to the Ohio Mental Health and Addiction Services, Bureau of Licensure and Certification, 30 E. Broad St., Columbus, Ohio, 43215-3430.
Facsimiles are not accepted and an incomplete application will be returned.

☐ Initial Application ☐ Renewal Application License Number: _____

Facility Information:

Name of Adult Foster Home:		Date of Application:
Street Address:		County:
City, Zip Code:		E-Mail:
Primary Number:	Secondary Number:	Facsimile:

Owner/Operator Contact Information (☐ Check if the Owner/Operator is the same as the manager):

Name of Owner/Operator:	Work/Home:
Street Address:	Cell Phone:
City, Zip Code:	E-Mail:

Manager or Alternate Contact Information:

Name of Manager or Alternate Contact:	Work/Home:
Street Address:	Cell Phone:
City, Zip Code:	E-Mail:

1.) How many bedrooms are in the home?
☐ One ☐ Two ☐ Three ☐ Four ☐ Five or more

2.) Are there any Residential State Supplement (RSS) residents in this home?
☐ Yes ☐ No

3.) Do you agree to accept referrals from the RSS program?
☐ Yes ☐ No

4.) How many adult residents will you provide accommodations and supervision?
☐ 1 ☐ 2

5.) Do you own this home?
☐ Yes ☐ No

6.) Do you rent this home?
☐ Yes ☐ No

7.) Are you employed? ☐ Yes ☐ No If yes, please list your work schedule:
☐ Sun ☐ Mon ☐ Tues ☐ Weds ☐ Thurs ☐ Fri ☐ Sat _____ am until _____ pm.

8.) Are you dependent upon the resident(s) income to support your household?
☐ Yes ☐ No

9.) A current and compliant copy of a fire safety inspection report from a certified fire safety inspector is enclosed.
☐ Yes ☐ No

Name of AFoH Facility: _____

Health Information:

Are you or any family members living with you under a doctor's care for any health problem or disability? ☐ Yes ☐ No

If Yes, please describe:

Have all persons functioning as caregiver in your home, i.e., adults who provide a personal care service or supervision in an adult foster home, provided you with a copy of a signed statement from a licensed physician acting within the scope of the physician's practice that states the caregiver has no medical or physical condition that would impact the treatment, safety, health, or welfare of the resident? ☐ Yes ☐ No

If No, please explain:

Absences from Home and Contingency Plan:

Have you enclosed a copy of your contingency lans covering the unexpected absence, vacation, or disability of the home's caregiver(s) with your application? ☐ Yes ☐ No

Criminal Records Check:

Have criminal records checks been conducted in compliance with section 109.572 of the Ohio Revised Code for all caregivers and any other persons providing services to residents for more than six hours over a forty-hour period? ☐ Yes ☐ No

If no, please explain:

Name:	Work/Home Phone:
Street Address:	
City, Zip Code:	

If you rent this facility, you must include a copy of the signed lease agreement and provide a signed statement from both you and the landlord indicating that the landlord allows you to use the residence as an adult foster home for a minimum of two years.

To the best of my knowledge, the information contained in this application is accurate and complete.

_____ _____

Signature of Adult Foster Home Manager/Operator Date