Iowa Department of Human Services

APPLICATION FOR CERTIFICATION

To the Applicant Family:

We invite your application for our family-life home program. We ask that you complete this questionnaire so that we might better understand you, your home, your situation, and your interests. The information you provide our Department in this questionnaire, in interviews, or otherwise, will be held in strictest confidence.

Please return this questionnaire by mail or bring it with you at the time of your next office visit.

Name	
Position	
Address	
Telephone	Date

Iowa Department of Human Services

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Persons in Household:

	Name	Sex	Birthdate	Education
Head of Household				
Spouse				
Children or other Adults				
Others				

Address
Telephone Number

Do all members of the household know about and agree to this application?

____

____

Reasons for applying:

____

____

____

____

____

Employed persons in the household:

Name	Occupation	Number Hours Worked Weekly

Family annual income range:

- ❑ Less than $10,000
- ❑ $10,000-$15,000
- ❑ $15,000-$20,000
- ❑ More than $20,000

How well does this income provide for the family: (Adequately, comfortably, barely enough, or etc.)

____

____

Experience of family in boarding or caring for children or adults? (Please describe.)

____

____

Has any member of the family been employed in caring for or working with people? (Please give details.)

____

____

Do any members of the household have any physical or mental problems or impairments? (If so, please describe briefly.)

____

____

Is any member of the household under treatment by a physician at this time? (If so, please specify briefly.)

____

____

Family religion and church membership?

____

____

Family recreation and interests?

____

____

____

Check the following items which pertain to your home:

- ❑ House
- ❑ Duplex
- ❑ Apartment
- ❑ Frame Structure
- ❑ Brick or Stone
- ❑ Other Structure
- ❑ Rented
- ❑ Owned
- ❑ Other Occupancy
- ❑ Farm
- ❑ Rural
- ❑ Town
- ❑ Suburban
- ❑ Residential Area
- ❑ Commercial Area

Please fill in the following items which pertain to your home:

______Number of rooms ______Number of stories ______Number of stairways
______Number of bedrooms ______Number of bathrooms

What is the general physical condition of the house?

____

____

What pets live with your family?

____

____

What is the distance of your home from the nearest town or business area? (Approximate miles.)

____

____

From the nearest doctor or hospital?

____

____

Please describe the transportation available from your home.

____

____

Please describe the sleeping and private living quarters you intend for the client. (Include location, size, furnishings, comfort, etc.)

____

____

Would you accept the following kind of a person as a member of your household:

	Yes	No	Perhaps
Elderly (age 65 older)	❑	❑	❑
Mentally retarded (mild or moderate)	❑	❑	❑
Blind (partial or totally)	❑	❑	❑
Physically disabled	❑	❑	❑
Former mental hospital patient.	❑	❑	❑
Former alcoholic	❑	❑	❑
Former county care facility resident	❑	❑	❑
Former nursing home resident	❑	❑	❑
On work-release from a correctional or penal institution	❑	❑	❑
Diabetic	❑	❑	❑
Epileptic	❑	❑	❑

	Yes	No	Perhaps
Wheelchair user	❑	❑	❑
Crutch or cane user	❑	❑	❑
Requires a special diet	❑	❑	❑
Smoker	❑	❑	❑
Social drinker	❑	❑	❑
Physically unattractive	❑	❑	❑
Withdrawn	❑	❑	❑
Very talkative	❑	❑	❑
Enuretic	❑	❑	❑
Pregnant	❑	❑	❑
Requires regular medical attention	❑	❑	❑
Has close ties to family or friends	❑	❑	❑

Please describe the kind of person you would want for placement in your home:

____

____

Please give the names and addresses of references unrelated to your family as follows:

	Name	Address	Telephone
Family's Physician(s)			
Either A clergyman or Businessman:			
A Neighbor or Friend:			

Head of Household's Signature
Spouse's Signature
Date