INDEPENDENT HORIZONS LLC.

# Extended Family Home Worksheet

| | | | | | |
|---|---|---|---|---|---|
| Name: | | Date of Birth: | | | |
| Address: | | City, State: | | Zip Code: | |
| Phone (H): | | (W): | | (C): | |
| Place of Employment: | | | | | |
| Address: | | | | | |
| Occupation/ Military: | | | | | |
| Hours & Days Worked: | | | | | |

Hobbies/Special Interests/Membership of Clubs and Organizations:

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Have you been a care provider before?

| | | | | | |
|---|---|---|---|---|---|
| Yes: | | No: | | If yes, please give dates & details: | |

| | | | | |
|---|---|---|---|---|
| Do you have a valid driver's license? | Yes: | | No: | |

| | | | | |
|---|---|---|---|---|
| Would you be willing to provide local transportation for outings, doctor appointments, etc.? | Yes: | | No: | |
| Do you rent or own your own home? | Rent: | | Own: | |
| If renting, name of landlord: | Name: | | | |
| Address of landlord: | | Phone #: | | |

## Household Members

| Name | Date of Birth | Occupation | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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## Physical description & Health

Do you have any medical/mental/physical disability which would limit your ability to provide care?

| | Yes | | No | If yes, please describe the condition: |
|---|---|---|---|---|
| | | | | |

List current medications taken:

_____

## Education/Experience

What is the highest level of education you have completed?

_____

What experience (schooling and/or work skills) do you have that would enhance your ability to care for an individual with a developmental disability?

## Employment History

Briefly describe jobs over the past 3 years, beginning with your current occupation. Include name of employer, dates of employment, your work title and brief description of responsibilities. (If you need more space you may use the back of this sheet.)

_____

## Violations

| Have you ever been arrested for anything other than a minor traffic violation? | Yes: | | No: | |
|---|---|---|---|---|

If yes, please explain (please provide brief descriptions and dates)

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## Living Arrangements

What would the living arrangements be for the individual?

Would you accept an individual who: (Please check)

| Yes | No | Description of Need: |
|---|---|---|
| | | Requires help with personal hygiene (bathing, shaving, etc.) |
| | | Has poor vision or hearing |
| | | Is physically handicapped – non-ambulatory, uses prosthetics |
| | | Smokes tobacco |
| | | Alcoholic beverages |
| | | Requires your assistance to administer/monitor their medication |
| | | Is diabetic (special diet) |
| | | Is unable to be left alone |
| | | Exhibits behavioral problems |

| How many individuals do you wish to care for? | |
|---|---|

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| | | | |
|---|---|---|---|
| Do you have a gender preference? | | Age preference? | |

Please list any other consideration:

List 3 Personal References (Non-relatives):

| Name | Address | Phone # | Years Acquainted |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Comments/Additional information:

Signature: _____

IH 10/10/2013