



Lifesharing Application

Applicants are considered without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-job-related medical condition or disability.

Date of Application:	
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Primary Provider Name									
	Maiden Name, if applicable:								
Street Address:	Township:								
City, State, Zip Code:	County:								
<p style="text-align: center;">Contact Information <i>Check your preferred method(s) of communication.</i></p> <table border="1"> <tr> <td>Work:</td> <td></td> </tr> <tr> <td>Cell:</td> <td></td> </tr> <tr> <td>Home:</td> <td></td> </tr> <tr> <td>Email:</td> <td></td> </tr> </table>	Work:		Cell:		Home:		Email:		<p>How long have you been at this address?</p> <p>I have been a resident of PA for more than 5 years. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If answered no, please list all states where you have lived with dates:</p> <p>Do you have a valid, PA state license and own a car? (required) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Work:									
Cell:									
Home:									
Email:									

Information Regarding the Secondary Providers: ***Please note: If you do not have a secondary provider, this will not disqualify you. If you are married, the secondary must be your spouse.*

Secondary Provider Name:	
<input type="checkbox"/> Same as primary	<input type="checkbox"/> Same as primary
Street Address:	Township:
City, State, Zip Code:	County:

<p align="center">Contact Information Check your preferred method(s) of communication.</p>	How long have you been at this address?								
	<p>I have been a resident of PA for more than 5 years. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please list all states (with dates) where you have lived:</p>								
	<p>Do you have a valid, PA state license and own a car? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<table border="1"> <tr> <td>Work:</td> <td></td> </tr> <tr> <td>Cell:</td> <td></td> </tr> <tr> <td>Home:</td> <td></td> </tr> <tr> <td>Email:</td> <td></td> </tr> </table>	Work:		Cell:		Home:		Email:		
Work:									
Cell:									
Home:									
Email:									

Please list ALL individuals living in your home:

First Name	Last Name	Age	Date of Birth	Relationship	Do they live in the home?

If you are the caregiver, parent, or guardian of any other individual (child or adult) not living in your home, please list in the space provided below.

First Name	Last Name	Age	Address (City, State)	With Whom Does S/He Live?

Description of home:

<p>Check Type of Home:</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Twin <input type="checkbox"/> Townhouse <input type="checkbox"/> Apartment <input type="checkbox"/> Row Home <input type="checkbox"/> Mobile Home <input type="checkbox"/> Ranch</p>	<p>Planned Occupancy: <i>What are the future plans concerning individuals living in the house? Will anyone be moving in/out?</i></p> <table border="1"> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>				
<p>Do you have any pets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Are you willing to transport a client to necessary appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, why?</p>				

Personal Information

<u>Primary Provider</u>		<u>Secondary Provider</u>	
Date of Birth (Month, Day, Year)		Date of Birth (Month, Day, Year)	
Social Security Number		Social Security Number	
US Citizen/Permanent Resident	<input type="checkbox"/> Yes <input type="checkbox"/> No	US Citizen/Permanent Resident	<input type="checkbox"/> Yes <input type="checkbox"/> No
Language(s) Spoken:		Language(s) Spoken:	

Work Experience (Please list current job)

<u>Primary Provider</u>		<u>Secondary Provider</u>	
Occupation		Occupation	
Employer		Employer	
Address		Address	
Usual Hours of Work		Usual Hours of Work	

Previous Provider Experience

<p>PRIMARY: Are you now or have you in the past provided residential/foster care in your home for children or adults? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>SECONDARY: Are you now or have you in the past provided residential/foster care in your home for children or adults? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If yes, please answer the following questions.</p> <ul style="list-style-type: none"> List month/year of service and agency name. Number of individuals placed in your care? Who initiated the withdraw/termination? Reason for withdraw/termination 	<p>If yes, please answer the following questions.</p> <ul style="list-style-type: none"> List month/year of service and agency name. Number of individuals placed in your care? Who initiated the withdraw/termination? Reason for withdraw/termination

As part of the application process, a PA Department of Motor Vehicles Report, PA Criminal Record Check, PA Child Abuse History Clearance, FBI Record Check, local township police and local office of children and youth check will be completed.

Agreement

By signing, I also give Access Services permission to run the following online clearances/searches: County Civil Court Docket Search, PA Common Pleas Court Docket Search, RTK (Right to Know) Request, EPLS (Excluded Parties List System, checks if excluded from receiving Federal contracts, assistance, etc.), LEIE (List of Excluded Individuals/Entities, parties ineligible to participate in any federal health care program), the Medichex List (identifies those who are precluded from participation in the Medical Assistance Program), and a Department of Motor Vehicle Report (record of your driving history). In addition, Access Services reserves the right to have any of the above clearances updated/rerun at any time.

I certify that all information furnished in this application is correct and complete, and I understand that any false statement or omission of material/fact may disqualify me from further consideration in becoming a Provider. I also understand that either party, applicant or Access Services, may terminate the approval/denial process of becoming a foster/host family provider at any time without obligation or justification.

Primary Provider's Signature

Date

Spouse or Secondary's Signature

Date

Access Services

All information received on this application will be handled with the utmost care and confidentiality.