A Beyond Shelter LLC.
Host Home Application

PLEASE COMPLETE AND RETURN VIA
Email: ABeyondShelter@gmail.com
Fax#: 833-415-0520

*****PLEASE READ TEXT IN RED BEFORE COMPLETING THIS APPLICATION*****

PLEASE READ PRIOR TO COMPLETING:
You are applying for a position to become a contractor of A Beyond Shelter LLC., a legal entity of Health and Human Services for the State of Texas (HCS) Home and Community Based Services program to ensure the health and safety of a person with disabilities.

Due to fraud prevention and control, the following requirements apply to the application process and as well should you become employed.

1. **ONLY ORIGINAL DOCUMENTS**, no photographs of documents will be accepted.
2. **ONLY ORIGINAL SIGNATURES**, no e-signatures or copying of signatures will be accepted.
3. **REQUIRED TRANSMISSION VIA EMAIL OR FAX**, no cell phone transmission, scanning submission of any kind, as they are unsecured devices.
4. **COMPLETE ALL FORMS IN THEIR ENTIRETY**

HCS is a Medicaid Waiver program, frequently audited by Medicaid, Health and Human Services, Adult Protective Services and Courts of Law. Failure to adhere to any of these requests will mean automatic rejection of your application and or termination of your employment.

A Beyond Shelter's licensing process includes a criminal history background check for *ALL adult occupants of the home*. It is the obligation of all state contracted agencies to determine if an applicant has ever committed an act of abuse, neglect, exploitation, misappropriation, or misconduct.

A Beyond Shelter does not discriminate based on age, race, religion, gender, sexual orientation or marital status.

First Name:_____ Last Name_____ Middle _____

Phone #_____ Email: _____

Address: _____

City:_____ State:_____ Zip: _____

(IDENTIFICATION)

Valid Driver's License or ID # _____

Social Security# _____

Date of Birth: _____

Gender

- □ Male
- □ Female
- □ Gender that you identify with _____
- □ Refuse to Identify

Age: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____

Languages spoken in home other than English: _____

Ethnicity

☐ Decline to Specify ☐ Black ☐ White ☐ Hispanic ☐ Asian

☐ Not named above _____

☐ More than one race _____

Education

☐ Degree (Name)_____

☐ High School Diploma or GED (Year)_____

If none of the above, please explain so that we may provide you with a proficiency test

_____

_____

List all previous addresses within the last FIVE years:

Move in Date MM/YY	Move Out Date MM/YY	Street Address, City, State, Zip Code

Please list those persons other than yourself who reside or visit your home whether temporary or permanent i.e. college student, father or mother of children etc.

Name	Age	Relationship

(SOCIAL MEDIA)

Any other Personal and Professional Emails: _____

_____

Personal and Professional Websites: _____

_____

(Include Face Book, IG, Twitter, blogs etc.) _____

(CITIZENSHIP)

Are you a United States citizen? ☐ Yes ☐ No
If no, please answer questions A & D.

A. How long have you lived in the United States? _____

B. In what country does your citizenship reside? _____

C. How long do you plan to live in the United States? _____

D. Do you have a Green Card? ☐ Yes ☐ No
If no, what are your plans, if any, for applying for U.S. citizenship? Please explain.

_____

(EMPLOYMENT)

Primary Caregiver Applicant #1	**Spouse or Co-Applicant #2**
Occupation	Occupation
Employer	Employer
Employer Address	Employer Address
Work Phone	Work Phone
Days Per Week	Days Per Week
Total Hours Per Week	Total Hours Per Week

Can you receive calls at work? ☐ Yes ☐ No

(PRIOR EXPERIENCE)

Have you provided or applied to provide foster care before? ☐ Yes ☐ No

If "Yes", what agencies did you work with? (Please provide name, address, and telephone number and when).

_____

_____

(MARITAL STATUS)

E. Are you currently married? ☐ Yes ☐ No

F. If married, how long have you been married? _____

G. If not married, are you in a committed relationship? ☐ Yes ☐ No

H. If in a committed relationship, how long? _____

Any other types of relationships that might or might not be of significance to a client placed in your home, please explain and describe frequency:

_____

(CRIMINAL HISTORY)

For any "yes" answers, please see (blank page 9) to add a detailed explanation in writing.

☐ Y ☐ N Have you ever been convicted of a felony or misdemeanor?

☐ Y ☐ N Have you ever been charged with any sexual offenses, offense relating to children, or crime of violence?

☐ Y ☐ N Have you ever been reported to any organization or registry for abuse or misconduct involving children?

☐ Y ☐ N Do you have any disciplinary action or investigation pending by an employer, other organization, professional association, or licensing body, for violence, sexual misconduct, or misconduct involving children?

☐ Y ☐ N Have you ever been disciplined or dismissed from any volunteer position or employment for any reason or following an allegation of sexual misconduct, physical aggression, verbal aggression, or other inappropriate behavior or conduct?

☐ Y ☐ N Have you ever been reprimanded, or asked to leave your membership in an organization in which you were volunteering?

☐ Y ☐ N Have you ever been subject of a complaint or disciplinary proceeding against any professional license or professional affiliation held by you?

(SAFETY)

1. Do You have any weapons/firearms in the home? ☐ Yes ☐ No

2. If yes how many and what type? _____

3. Do you keep your weapons/firearms locked away? Where do you store your weapons/firearms?

_____

4. Do you lock your ammunition away separately? ☐ Yes ☐ No

(RELIGION)

1. Do your religious beliefs prohibit certain medical treatment? ☐ Yes ☐ No
   If yes, explain:

   _____

2.. Would you object to a client celebrating holidays of their own religious beliefs? ☐ Yes ☐ No
   If yes, explain:

   _____

(CARE KNOWLEDGE)

1. Describe any experience you have working with special needs persons of any age.

   _____

   _____

2. Do you have any reservations in working with persons who suffer from forms of mental illness?

   _____

   _____

(PETS)

1. Do you have any pets? ☐ Yes ☐ No
2. If Yes, are they vaccinated, and can you show proof? ☐ Yes ☐ No

   Please list quantity, species, and age _____

   _____

   _____

Type of Current Residence

☐ Single Family Dwelling

☐ Condo or Townhouse

☐ Duplex

☐ Apartment

☐ Mobile Home

There is a maximum of THREE clients allowable per home. The requirement is at least 9x9 square feet per room with a door that closes for privacy.

How many rooms do you have available for potential placements? _____

Is your home Wheelchair Accessible?

☐ YES ☐ NO

Is incontinence a deal breaker?

☐ YES ☐ NO

Gender Preferred ☐ FEMALE ☐ MALE ☐ EITHER

Please list if any reservations or "DEAL BREAKERS" when asking to accommodate a clients needs i.e.: injections, blind, deaf, non-verbal etc.?

_____

_____

_____

_____

(EMOTIONAL AND MENTAL HEALTH)

Abiding by the ADA (American Disabilities Act) We do not require any specific disclosure of medical or mental issues. Are there any health issues that would prohibit or inhibit your care for a client? ☐ Yes ☐ No

If Yes, please explain: _____

_____

(PHYSICAL HEALTH)

Do you consider yourself…

☐ Very Healthy ☐ Healthy ☐ Somewhat Healthy ☐ Un-Healthy

Abiding by the ADA (American Disabilities Act) We do not require any specific disclosure of medical or mental issues. Are there any health issues that would prohibit or inhibit your care for a client? ☐ Yes ☐ No

If Yes, please explain: _____

_____

Do you currently SMOKE? ☐ Yes ☐ No, Frequency _____

Do you currently DRINK BEER OR ALCOHOL? ☐ Yes ☐ No, Frequency _____

☐ **INITIAL HERE TO THE FOLLOWING:**

I understand that the clients that I will care for under the HCS program are Adults with Intellectual and or Developmental Disabilities and could potentially have forms of mental illness and other disorders.

☐ **INITIAL HERE TO THE FOLLOWING:**

I understand that my required documentation of services is solely my responsibility. I also understand that my provider agency, A Beyond Shelter LLC will send a claim to Medicaid for billing of the services that I provide to the consumer; therefore my paperwork must be the original document, timely, complete, legible, with my original signatures and available for Medicaid audit at all times.

Applicant Name Printed: _____

Applicant Signature: _____

Date: _____