Karuna Care Services
735 Cristo Ln
Lafayette, CO 80026
Phone: 720.684.7606
Fax: 303.862.9185

HOST HOME PROVIDER APPLICATION

Please be advised that this application must be thoroughly completed for processing

Date Application was completed: ____________________

Applicant's Full Name: _________________________ **D.O.B.:** ___________________________

Address: ____

Street Address / Apt # **City** **Zip Code**

Contact Number: ______________________

Contact Email Address: ______________________

Please List all individuals living in your home. Those who are 18 years of age or older. Please submit a background check form for each individual over the age of 18

Name:	Relationship:
____	____
____	____
____	____
____	____
____	____

Have you or anyone living in your home ever been convicted of a felony? Yes / No
If Yes, Please briefly explain the circumstance of the conviction:

____
____
____
____

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Have you or anyone living in your home ever been convicted of a misdemeanor? Yes / No
If Yes, Please briefly explain the circumstance of the conviction:

____
____
____
____

Please list any traffic violations incurred within the last three (3) years:

Violation: ______________________________ **Date of Violation:** ________________

Violation: ______________________________ **Date of Violation:** ________________

Violation: ______________________________ **Date of Violation:** ________________

The agency conducts a Colorado Bureau of Investigation (CBI) Records Check and Colorado Motor Vehicle check on all applicants. Do yon have any objection to this process? Yes / No

Please Provide Three Personal References:

1. ____________________ ____________________ ____________________
Name: **Email Address:** **Contact number:**

2. ____________________ ____________________ ____________________
Name: **Email Address:** **Contact number:**

3. ____________________ ____________________ ____________________
Name: **Email Address:** **Contact number:**

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EMPLOYMENT REFERENCES

Please Provide Three Employment References:

1. ______________________ ______________________ ______________________
Organization: **Supervisor Name:** **Contact Number:**

______________________ ______________________
Email Address: **Employment Dates:**

Brief Description of Job Duties:

____
____
____
____

2. ______________________ ______________________ ______________________
Organization: **Supervisor Name:** **Contact Number:**

______________________ ______________________
Email Address: **Employment Dates:**

Brief Description of Job Duties:

____
____
____
____

3. ______________________ ______________________ ______________________
Organization: **Supervisor Name:** **Contact Number:**

______________________ ______________________
Email Address: **Employment Dates:**

Brief Description of Job Duties:

____
____
____
____

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Host Home Provider Requirements

Do you have any medical issues or concerns that may potentially impair your ability to meet the responsibilities of a contracted Host Home Provider? Yes / No

If yes, please briefly explain:

____

____

____

Are you currently taking any medication that would prevent you from driving a vehicle or impair your ability to provide adequate supervision? Yes / No

If yes, please briefly explain:

____

____

____

Do you own or rent your home? Own / Rent
Do you currently carry homeowner or renters insurance? Yes / No

Karuna Care Service Providers is required by Colorado State regulations to verify and retain proof of home owners / renters insurance for all current providers. Home Owners Insurance or Renters Insurance must be submitted to KCS prior to any placement of a consumer in your home.

Do you have any objections to providing the agency copies of your insurance? Yes / No

Karuna Care Service Providers is required by Colorado State regulations to verify and retain proof of Auto Insurance in keeping with state standards for all current providers. Auto Insurance must be submitted to KCS prior to any placement of a consumer in your home.

Do you have any objections to providing the agency copies of your insurance? Yes / No

Karuna Care Service Providers is required by Colorado State regulations to verify and retain proof of Professional Liability Insurance in keeping with Colorado Division for Developmental Disabilities standards for all current providers. ***Please note, KCS can assist you in finding providers for such insurance.***

Do you have any objections to providing the agency copies of your insurance? Yes / No

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In looking to provide care as a Host Home Provider is there a specific client population that you would prefer to work with? (i.e. individuals with significant medical needs or significant behavior needs)

____
____
____
____

In looking to provide care as a Host Home Provider is there a specific client population that you are unwilling or unable to work with? (i.e. individuals who have been adjudicated)

____
____
____
____

Is your home wheelchair accessible? Yes / No

Would you be willing to provide services to a person who utilizes a wheelchair? Yes / No

______________________________ ______________________
Applicant Signature: **Date:**

____
Printed Applicant Name:

This section is for KCS office use only		**Application Approval:**	**Yes / No**
References completed by:		**Completion Date:**	
Professional Reference:	**Completed Contact Date:**	**Personal Reference:**	**Completed Contact Date:**
1:		**1:**	
2:		**2:**	
3:		**3:**	