- PERSONAL STATEMENT OF HEALTH -
For Adult Foster Care Home Providers
Department of Public Health and Human Services
Office of Inspector General
Community Residential Program Licensing

Name: _____ Phone #: _____

Facility Name: _____

Address: _____ City: _____State: __MT____ Zip Code: _____

SSN: _____ Date of Birth: _____

Pursuant to ARM 37.100.165(3), a personal statement of health for licensure form provided by the department must be completed for each person subject to the requirements of this rule. The form must be submitted to the department with the initial application for licensure and annually thereafter.

The licensing surveyor completing the facility assessment and/or the Licensure Bureau Chief who issues the license will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professionals to support your responses. The purpose of the questions is to help determine if you have health issues that may affect your ability to safely provide care.

Please answer the following questions by entering an "X" in the appropriate box for each question.

1. [ ] Yes [ ] No Do you have any physical or mental health problems which might affect your ability to provide care?

2. [ ] Yes [ ] No Have you been convicted of a crime involving child or elder abuse or neglect, including sexual abuse, physical assault, or other acts of violence?

3. [ ] Yes [ ] No Have you been named a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult)?

4. [ ] Yes [ ] No Are you currently diagnosed or receiving therapy or medication for a mental health problem which might affect your ability to provide care?

5. [ ] Yes [ ] No Have you received counseling or treatment related to a chemical dependency (drugs or alcohol) within the past three years?

If you answered "Yes" to any of the questions above, please explain on the next page.

The department may request additional supportive documentation from your medical practitioner, psychologist, or counselor. If determined to be necessary, the licensing surveyor can discuss with you the type of additional information needed. If an evaluation or statement is needed, the surveyor can assist you in completing the authorization form for your physician or other appropriate professional. Any additional evaluations, tests, or visits to your physician or other professional(s) must be paid by you.

Please use the space below to explain any "Yes" answers marked in questions 1 through 5 on the previous page. Include additional pages if necessary.
Please read, then sign and date.

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate, and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for an adverse license action in accordance with ARM 37.100.130 I understand that this information is confidential and to be used by the Department of Public Health and Human Services for the administration of the licensure program. I hereby consent to the use of the information for such purposes.

Signature: _____ Date: _____