STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION
ADULT FOSTER CARE
PERSONAL STATEMENT OF HEALTH FOR LICENSURE

NAME (PLEASE PRINT) BIRTHDATE

FACILITY NAME CONTACT PHONE NUMBER

ADDRESS CITY, STATE, ZIP

Pursuant to ARM 37.100.165 a personal statement of health for licensure form provided by the department must be completed for each adult member of the household (does not include adult foster care residents) and all adults providing care.

The Quality Assurance Division Health Care Facility Surveyor will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement form your physician or other appropriate professional 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? (If yes, please explain in Section 6 on reverse side.)

2. { }Yes { }No Have you been convicted of a crime involving child or elder abuse or neglect, including sexual abuse, physical assault, or other act of violence? (If yes, please explain in Section 6 on reverse side.)

3. { }Yes { }No Have you ever been named as a perpetrator in a substantiated report of child or adult abuse or neglect (or exploitation of an adult) if yes, please explain in Section 6 on reverse side.

4. { }Yes { }No Are you currently diagnosed or receiving therapy or dedication for a mental health problem, which might affect your ability to provide care? (If yes, please explain in Section 6 on reverse side.)

5. { }Yes { }No Have you received counseling or treatment related to chemical dependency on drugs or alcohol within the past three years? (If yes, please explain in Section 6 on reverse side.)

(**OVER)**

DPHHS-QAD/CRL – 005

The department may request additional supportive documentation from you 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 specialist can assist you in completing the authorization form for your physician or other appropriate professional. **Any evaluation, test, or visits to your physician or other professional(s) must be paid by you.**

6. Please use the space below to explain any "yes" answers marked in questions 1 through 5. attach additional pages if necessary.

_____
_____
_____
_____
_____
_____
_____
_____

PLEASE READ, THEN SIGN AND DATE:

**ATTESTATION**

In accordance with 52-3-825 (2) MCA, and ARM 37.100.138 and ARM 37.100.165 I certify I have never been convicted of a crime involving violence, fraud, deceit, theft, abuse, neglect of a child or an adult.

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 understate 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 this information is confidential and to be used by the Department of Public Health and Human Service for the administration of the licensure program. I hereby consent to the use of this information for such purposes.

**SIGNATURE:_____DATE_____**

Local Office
**PLEASE RETFURN TO:** DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION
2401 COLONIAL DR 2ND FLOOR
HELENA MT 59620-2953

(REV 11/14)