



All Heart Health Care Ministry Inc.

Family Model Provider Questionnaire Form

***Please note that the purpose of these questions is to find the most ideal placement for both your family and the Person(s) Supported. ***

Name: _____ **Phone Number:** _____

Email: _____

Gender: Male/Female **Preferred Gender for Person(s) Supported (optional):** Male/Female

Address: _____

Circle One: *Apartment or House?* If apartment, what floor? _____

County: _____

Number of Rooms: _____ **Number of Bathrooms:** _____

Number of Roommates (NOT including Person(s) Supported): _____

Pets? Yes/No

If yes, please tell us the type of pet and how many:

Children? Yes/No

If yes, please explain (age, gender, number of children):

Are you a smoker? Yes/No

Are you comfortable with someone smoking in your home? Yes/No

Number of Person(s) Supported in the home presently: _____

How many Person(s) Supported from our agency are you comfortable with supporting? _____

Handicap accessible (wheelchair, ramp, bathroom modifications, wider hallways, etc.)? Yes/No

If yes, please explain: _____



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Do you have a full-time job? Yes/No

If yes, please explain: _____

Do you have an age group preference for the Person(s) Supported (optional)? Yes/No

If yes, please explain: _____

Do you have any religious preferences (optional)? Yes/No

If yes, please explain: _____

Do you have a preference to the level of independence (total care, etc.)? Yes/No

If yes, please explain: _____

Do you have a secondary support staff readily available to work with you? Yes/No

If yes, please fill out the following information.

Name: _____ **Phone Number:** _____

Email: _____ **Relationship:** _____

Gender: Male/Female

Availability: Please specify hours and days of the week.



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Tell us about a typical day in your household as a family.

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What is your understanding of a role of a Family Model Provider?

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What is your understanding of the Person(s) Supported's role in your family?

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What is your understanding of the other family members' roles?

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Please describe your experience with dealing with behaviors.

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Why is the family interested in providing services for people with intellectual and developmental disabilities?

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Print Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Print Name of Agency Representative: _____

Signature of Agency Representative, Title: _____ Date: _____