ACCESS SERVICES
unlocking potential

Lifesharing Application

Applicants are considered without regard to race, color, religion, sex, national origin, age, marital or veteran status, or the presence of a non-job-related medical condition or disability.

Date of Application:	

Primary Provider Name	
	Maiden Name, if applicable:
Street Address:	Township:
City, State, Zip Code:	County:

Contact Information
Check your preferred method(s) of communication.

Work:	
Cell:	
Home:	
Email:	

How long have you been at this address?

I have been a resident of PA for more than 5 years.
☐ Yes ☐ No

If answered no, please list all states where you have lived with dates:

Do you have a valid, PA state license and own a car? (required)
☐ Yes ☐ No

Information Regarding the Secondary Providers: ***Please note: If you do not have a secondary provider, this will not disqualify you. If you are married, the secondary must be your spouse.*

Secondary Provider Name:	
☐ Same as primary	☐ Same as primary
Street Address:	Township:
City, State, Zip Code:	County:

Contact Information
Check your preferred method(s) of communication.

Work:	
Cell:	
Home:	
Email:	

How long have you been at this address?

I have been a resident of PA for more than 5 years.
☐Yes ☐No

If no, please list all states (with dates) where you have lived:

Do you have a valid, PA state license and own a car?
☐Yes ☐No

Please list ALL individuals living in your home: ***Please include ALL adult children living outside the home.*

First Name	Last Name	Age	Date of Birth	Relationship	Do they live in the home?

If you are the caregiver, parent, or guardian of any other individual (child or adult) not living in your home, please list in the space provided below.

First Name	Last Name	Age	Address (City, State)	With Whom Does S/He Live?

Description of home:

Check Type of Home:

- ☐ Single
- ☐ Twin
- ☐ Townhouse
- ☐ Apartment
- ☐ Row Home
- ☐ Mobile Home
- ☐ Ranch

Planned Occupancy:
What are the future plans concerning individuals living in the house? Will anyone be moving in/out?

Do you have any pets? ☐Yes ☐No

Are you willing to transport a client to necessary appointments?
☐Yes ☐No
If no, why?

Personal Information

Primary Provider		Secondary Provider	
Date of Birth (Month, Day, Year)		Date of Birth (Month, Day, Year)	
Social Security Number		Social Security Number	
US Citizen/Permanent Resident	☐ Yes ☐ No	US Citizen/Permanent Resident	☐ Yes ☐ No
Language(s) Spoken:		Language(s) Spoken:	

Work Experience (*Please list current job)*

Primary Provider		Secondary Provider	
Occupation		Occupation	
Employer		Employer	
Address		Address	
Usual Hours of Work		Usual Hours of Work	

Previous Provider Experience

PRIMARY: Are you now or have you in the past provided residential/foster care in your home for children or adults? ☐Yes ☐No	**SECONDARY:** Are you now or have you in the past provided residential/foster care in your home for children or adults? ☐Yes ☐No
If yes, please answer the following questions. • List month/year of service and agency name. • Number of individuals placed in your care? • Who initiated the withdraw/termination? • Reason for withdraw/termination	If yes, please answer the following questions. • List month/year of service and agency name. • Number of individuals placed in your care? • Who initiated the withdraw/termination? • Reason for withdraw/termination

As part of the application process, a PA Department of Motor Vehicles Report, PA Criminal Record Check, PA Child Abuse History Clearance, FBI Record Check, local township police and local office of children and youth check will be completed.

Agreement

By signing, I also give Access Services permission to run the following online clearances/searches: County Civil Court Docket Search, PA Common Pleas Court Docket Search, Megan's Law (sexual offender database), EPLS (Excluded Parties List System, checks if excluded from receiving Federal contracts, assistance, etc.), LEIE (List of Excluded Individuals/Entities, parties ineligible to participate in any federal health care program), and the Medicheck List (identifies those who are precluded from participation in the Medical Assistance Program). In addition, Access Services reserves the right to have any of the above clearances updated/rerun at any time.

I certify that all information furnished in this application is correct and complete, and I understand that any false statement or omission of material/fact may disqualify me from further consideration in becoming a Provider. I also understand that either party, applicant or Access Services, may terminate the approval/denial process of becoming a foster/host family provider at any time without obligation or justification.

Primary Provider's Signature	**Date**	**Spouse or Secondary's Signature**	**Date**

Access Services

All information received on this application will be handled with the utmost care and confidentiality.