FAMILY CARE PROVIDER FACE SHEET

**To be updated annually*

Provider name: _____ Date: _____

Provider DOB: _____

Address of the home: _____

Telephone number of the home:_____

Date of contract agreement :_____ Max number of individuals:_____

Names and ages of all other individuals not receiving services but residing in the home:

NAME DOB

1.)_____ _____

2.)_____ _____

3.)_____ _____

4.)_____ _____

5.)_____ _____

(The maximum number of occupants in the home cannot exceed 7)

Names of all assistants:

Names of assistants	Do they transport individual(s) (yes or no) - If yes, a current copy of driver's license and insurance declarations must be on file