

**HOST HOME  
AND  
RELIEF  
CONTRACTORS**

**(Revised March 2017)**



# RESTORING **HOPE**

*one family at a time*

In October 2008, Restoring Hope, LLC, was founded by Chuck Swift, Owner and Administrator, to serve as a contract provider with the Department of Mental Health in the Springfield, MO, region. Having worked in the field of developmental disabilities since 1990, Chuck soon expanded the agency to include the Children's Division of Social Services in that region as well. In 2011, Chuck partnered with Jeff Smith, Co-Owner and Chief of Operations, and together the agency quickly grew to include the Poplar Bluff, Kirksville, and Central Missouri Regions. Today Restoring Hope, LLC, has 130 employees and contractors and supports 55 individuals with developmental disabilities throughout the State.

Our name says it all. Our agency aims high to "Restore Hope ... One Family at a Time." We strive to meet the needs of supporting individuals with developmental disabilities in the community by providing a safe, healthy, and wholesome environment through families who desire to build genuine relationships. Restoring Hope also provides opportunities to families in their homes that allows them a substantial income to help meet their financial needs.

We at Restoring Hope believe it is our mission to support those with disabilities by encouraging and assisting them to accomplish health and fitness goals, valued personal goals, and a sense of belonging in their home and community. We provide a supportive atmosphere of love, care, acceptance, dignity, and respect while upholding their right to:

- ◆ Be free to make decisions/choices
- ◆ Be an integral member of the community in which they live
- ◆ Be the best that they have the desire to become

We dream of making a difference in the lives of persons with developmental disabilities.

We dream of partnering with families to restore hope to their loved ones.

We dream of providing additional support and services to the underserved regions of our state.

We dream of partnering with state agencies and other providers to advocate for the rights of persons with developmental disabilities.

Restoring Hope, LLC

417.255.8781

P.O. Box 869

West Plains, MO 65775

**WERESTOREHOPE.com**



**RESTORINGHOPE**

**[www.werestorehope.com](http://www.werestorehope.com)**

### ***What is Restoring Hope?***

Restoring Hope, LLC is an agency that contracts with Missouri Department of Mental Health to provide residential services to persons with developmental disabilities. We also contract with the Children's Division of Missouri Department of Social Services. We strive to meet the needs of supporting individuals with developmental disabilities in the community by providing a safe, healthy, and wholesome environment through families who desire to build genuine loving relationships.

### ***What is a Host Home?***

A host home is when a family opens their home to take in and care for a child or an adult with a developmental disability. The host home program is very similar to the foster home model with added supports, built in relief, and better financial compensation. As a host home, you will assist the individual with maintaining a healthy, happy, and safe life within the home and community environment.

### ***Who can be a host home?***

There is not a standard profile for who can become a host home. Every host home has varying backgrounds and unique experiences that bring them to Restoring Hope. They may be stay-at-home moms, retired teachers, empty nesters looking for a way to still make a difference, retirees looking for additional income, or professionals in the human services field with experience caring for individuals with disabilities. There are no limitations in regards to sex, age, religion, relationship preference or ethnic backgrounds. Each host home brings a unique option for teams to consider when pairing individuals with host families.

### ***What do host homes do?***

Host families specifically follow the individualized support plan for the individual they are supporting. The actual level of support, supervision, and assistance varies. During the matching process the needs and preferences of both the host family and the individual are considered to ensure a successful placement.

### ***How do I get started?***

If you are interested in gaining additional information or partnering with Restoring Hope please contact us (417)-255-8781 or [info@werestorehope.com](mailto:info@werestorehope.com).

Please note that Restoring Hope, LLC, contracts with all of its Host Home providers and Relief Staff. If you wish to become a Host Home or Relief Staff, and are not already set up as your own LLC (Limited Liability Company), Restoring Hope will arrange and pay for filing fees for you to become one, and you will receive an EIN (Employer Identification Number). You will also sign a contractor's agreement with Restoring Hope.

For example, if you decide to contract with Restoring Hope and your name is Jane Miller, your company name may be Miller Lifecare Services, LLC, and every pay period (once a month) you will receive a paper check made out to your company. Since you are a contractor and not an employee, Restoring Hope will not take any taxes out of your payment, but you will be required to file your own taxes with the IRS.

As soon as you receive your EIN and your LLC documentation folder, you should open an LLC bank account. We also highly recommend you contact an accountant or CPA to help you file your own taxes. One great advantage to becoming an LLC, is that you are able take many more deductions on your taxes than if you were an employee. Your tax preparer can answer other questions you may have about the advantages of an LLC.

Thank you!

Diane Smithey  
Office Manager  
Restoring Hope, LLC

**Please send us copies of the following items:**

- Driver's License
- Social Security Card
- Proof of Auto Insurance
- High School or College Diploma or transcripts with graduation date, or GED
- Three letters of personal character reference with phone #
- Copy of Well Water Test Results (if you have well water)
- Proof of Fire Department Coverage (You do not need this if you live in the City or County and you pay for coverage through your personal property taxes. If you live in a rural area, you may be required to have membership with a volunteer fire department and proof is necessary.)
- Homeowner's/Renter's Insurance (if you are applying for a Host Home or Relief for Host Home)
- Lease Agreement (if you rent your primary residence, and are applying to be a Host Home or Relief for Host Home)

## **You will need to complete the following classes:**

- First Aid/CPR Certificate
- Medication Administration Certificate
- Mandt
- Tools of Choice Training
  
- Abuse & Neglect Test -

Go to [www.werestorehope.com](http://www.werestorehope.com)

Staff Login

Password: werestorehope

Click "OK"

Click on "Trainings" under Staff Login

Choose "Abuse and Neglect"

Click on Abuse Neglect Training

It may take several minutes to load.

Take quiz and afterwards send a copy of your certificate to

[diane@werestorehope.com](mailto:diane@werestorehope.com).

- Missouri Quality Outcomes -

Go to website: [www.werestorehope.com](http://www.werestorehope.com)

(Same login as above)

Choose "Missouri Quality Outcomes"

There will NOT be a quiz.

**Notify Diane at Restoring Hope (417-255-8781) when you finish reading this, so a certificate can be issued and placed in your file.**

As a Host Home or Relief Provider, you will need to have the following in your home:

- Fire Extinguisher (near the kitchen area)
- Smoke Detector (on every level and near every bedroom where consumer might sleep)
- Carbon Monoxide Detector (on every level)
- Secure Area to keep a locked medication box

## Application Form

Please print all information requested except signature  
**CONTRACTOR'S INFORMATION**

Please Complete Pages 1-5

Name: \_\_\_\_\_  
Last
First
Middle
Maiden

Present Address: \_\_\_\_\_  
Number
Street
City
State
Zip Code

How Long \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Type of School	Name of School	Location Complete mailing address	Number of Years Completed	Major & Degree
High School				
College				
Bus. Or Trade School				
Professional School				

Have you ever been convicted of a crime?      \_\_\_ No      \_\_\_ Yes

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DO YOU HAVE A DRIVERS LICENSE?      \_\_\_ Yes      \_\_\_ No

What is your means of transportation to and from work? \_\_\_\_\_

Driver's license number: \_\_\_\_\_ State issued: \_\_\_\_\_ Operator \_\_\_ Commercial \_\_\_ Chauffeur \_\_\_

Expiration date: \_\_\_\_\_

Have you had any accidents in the last 3 years?      \_\_\_ Yes      \_\_\_ No      If yes, how many? \_\_\_\_\_

Have you had any moving violations in the last 3 years? \_\_\_ Yes \_\_\_ No      If yes, how many? \_\_\_\_\_



## Application Form

Please print all information requested except signature

Please list two references other than relatives or previous employers

Name: _____	Name: _____
Position: _____	Position: _____
Company: _____	Company: _____
Address: _____	Address: _____
_____	_____
Telephone: (____) _____	Telephone: (____) _____

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## Application Form

Please print all information requested except signature

### WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name of Employer: Address: City, State, Zip: Phone Number	Name of last supervisor	Employment Dates	Pay or Salary
		From:	Start:
		To:	Final:
Your last job title:			
Reason for leaving? (Be specific)			
List the jobs that you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

Name of Employer: Address: City, State, Zip: Phone Number	Name of last supervisor	Employment Dates	Pay or Salary
		From:	Start:
		To:	Final:
Your last job title:			
Reason for leaving? (Be specific)			
List the jobs that you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

May we contact your present employer?  Yes  No

Did you complete this application yourself?  Yes  No      If No, who did? \_\_\_\_\_

## Application Form

Please print all information requested except signature

Name of Employer: Address: City, State, Zip: Phone Number	Name of last supervisor	Employment Dates	Pay or Salary
		From:	Start:
		To:	Final:
Your last job title:			
Reason for leaving? (Be specific)			
List the jobs that you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

Name of Employer: Address: City, State, Zip: Phone Number	Name of last supervisor	Employment Dates	Pay or Salary
		From:	Start:
		To:	Final:
Your last job title:			
Reason for leaving? (Be specific)			
List the jobs that you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.			

### MILITARY EXPERIENCE

Have you ever been in the armed forces?  Yes  No    If yes, what branch \_\_\_\_\_

Are you now a member of the National Guard?  Yes  No

Specialty \_\_\_\_\_    Date Entered \_\_\_\_\_    Discharge Date \_\_\_\_\_

## Application Form

Please print all information requested except signature

To the best of my knowledge, the information contained in the application is complete and accurate. I understand that providing false information is grounds for termination of contract. I authorize any person or organization, whether or not identified in this application, to provide any information concerning my previous employment, contract work, education, credit history, driving record, criminal conviction record, sexual offender registry or other qualifications for my volunteering. I also authorize any employer and all Contractors, including RESTORING HOPE, LLC to request and/or receive such information.

If hired, I agree to adhere to the state regulations while working with individuals with developmental disabilities. I understand that my contract may be terminated at any time, with or without cause, and with or without prior notice.

I HAVE READ AND UNDERSTAND THE ABOVE PROVISION

\_\_\_\_\_  
Signature of Contractor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Representative

\_\_\_\_\_  
Date

## Family Profile Sheet

Primary Staff's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Married, Single, Live-in Partner?: \_\_\_\_\_

Children?: \_\_\_\_\_, If Yes, list their ages and genders: \_\_\_\_\_

Do you live in town or in the country?: \_\_\_\_\_

Do you have any animals? \_\_\_\_\_, If Yes, explain: \_\_\_\_\_

Do you have a house, apt., trailer?: \_\_\_\_\_ Do you have an extra bedroom?: \_\_\_\_\_

Do you have reliable transportation?: \_\_\_\_\_ Car, truck, van, etc.?: \_\_\_\_\_

Do you like to attend church?: \_\_\_\_\_ Do you have internet/computer?: \_\_\_\_\_

Describe your interests, activities, life-style, etc.:

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List any other information you think might be of interest:

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## Family Care Service Registry Authorization

I, \_\_\_\_\_, hereby authorize a representative from my Employer or  
(Please Print Name)  
its agent, Restoring Hope, LLC, to use the following information to complete the Family Care Service Registry on my behalf. I also understand that my employer or its agent, Restoring Hope, LLC, will only use the following information for the sole purpose of this Registry. The following information includes:

- Full Name \_\_\_\_\_
- Date of Birth \_\_\_\_\_
- Current Street Address \_\_\_\_\_
- City \_\_\_\_\_
- County \_\_\_\_\_
- State \_\_\_\_\_
- Zip \_\_\_\_\_
- Social Security Number \_\_\_\_\_
- Telephone Number \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Specialist

\_\_\_\_\_  
Date

## Water and Fire Department Coverage

Please check all that apply, then sign and date below.

### WATER:

\_\_\_\_\_ I live within city limits and use city water.

\_\_\_\_\_ I live outside city limits and use county rural water.

\_\_\_\_\_ I live outside city limits and use well water. *(Please attach well water test.)*

### FIRE DEPARTMENT COVERAGE:

\_\_\_\_\_ I live within city limits and pay for fire department coverage through my personal property taxes. *(Please attach copy of personal property taxes.)*

\_\_\_\_\_ I live outside city limits and have fire department coverage with a volunteer fire department. *(Please attach a cancelled check or receipt from the fire department with your address and the name of the fire department on the receipt.)*

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\_\_\_\_\_  
Contractor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Restoring Hope, LLC Agency Representative

\_\_\_\_\_  
Date

## Confidentiality Agreement

I recognize and acknowledge that the services Restoring Hope, LLC provides to its consumers are confidential. To enable Restoring Hope, LLC to perform those services, consumers furnish confidential protected health information to the agency.

I, by reason of my work, volunteer activities, or by my presence with my employer, may come into possession of protected health information concerning the services performed by Restoring Hope, LLC for its consumers, even though I may not take any direct part in or furnish the services performed for those consumers. I agree that I will not at any time during or after my access to these records containing protected health information, disclose (which could mean giving someone records, or talking with someone) any such provided services or protected health information to any person or entity whatsoever, or other privileged information prepared that is not needed for consumer treatment, payment, or health care operations of Restoring Hope, LLC. I understand that the use or disclosure of such information may give rise to injury to the consumer and may violate state and federal confidentiality provisions.

I recognize and acknowledge that although the information contained in the consumer's file with Restoring Hope, LLC can only be disclosed by the consumer or his/her legal guardian, that the file and protected health information is the property of Restoring Hope, LLC, that no original records or portions of a consumer's file and protected health information shall be removed for any reason, and that I will keep no negatives, use no microfilm, or keep or sell any photocopies of computer discs to any second parties. I acknowledge that in receiving, storing, processing or otherwise dealing with any consumer protected health information from Restoring Hope, LLC, I am bound by any HIPAA federal regulations that apply, FERPA, by 42 CFR Part 2 et seq., "Confidentiality of Alcohol and Drug Abuse Patient Records", and by any other Missouri state law or other federal law that is applicable.

I, \_\_\_\_\_, (PRINT NAME), have read all of the above sections of this agreement, and I fully understand and shall comply with them. I understand that failure to comply may lead to sanctions for me and/or my employer .

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Confidentiality Quiz

Please check "yes" or "no"

Is it breaking confidentiality....

1. .... if you ask or respond to the question, "Is that person a client of DFS or DMH?  Yes  No
2. .... if you dress or undress someone in front of housemates and/or other persons?  Yes  No
3. .... if you give the full name of anyone you support apart from other staff members, guardians, and/or DMH personnel?  Yes  No
4. .... if you give the condition of a consumer's health if you are asked in a grocery store?  Yes  No
5. .... if you discuss someone you support's behavior/health/appointments with your own personal family members?  Yes  No
6. .... if you introduce someone to your friends and family?  Yes  No
7. .... if you discuss the individual's specific concerns in a group meeting where staff members from other homes are present?  Yes  No
8. .... if you discuss the individual you support toileting issues in front of others who do not support that individual?  Yes  No
9. .... if you assist in enrolling someone in a club or social group?  Yes  No
10. ....if you talk on the phone about an individual in front of others who do not support that individual?  Yes  No
11. .... if you discuss about individuals the fact that they receive Medicaid benefits or Food Stamps?  Yes  No
12. ....if you discuss an individual's talents, likes, or dislikes when the situation calls for supporting someone in the community or in a relationship?  Yes  No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Specialist

\_\_\_\_\_  
Date

**CONSUMER RIGHTS AGREEMENT**  
**Missouri Department of Mental Health**

**THE CONSUMER SHALL BE ENTITLED TO THE FOLLOWING RIGHTS WITHOUT LIMITATION**

- Due Process
- To have humane care and treatment, to the extent that the facilities, equipment and personnel are available for medical care and treatment in accordance with the highest standards accepted in medical practice
- To have safe and clean housing
- To attend religious services
- To receive prompt evaluation and care, treatment, habitation, or rehabilitation
- To be treated with respect
- To be the subject of an experiment only with the consumer's consent or the consent of the person legally authorized to act for the consumer
- To have the consumer's private doctor examine the consumer at his/her own expense
- To be evaluated and cared for in the least restrictive environment
- To refuse hazardous treatment or surgery unless ordered by a court
- To request and have a second opinion before hazardous treatment or irreversible surgery, except in emergencies
- To have nourishing, well-balanced meals
- To not work unless it is a part of his/her treatment, rehabilitation, or habilitation
- To be free from verbal or physical abuse
- To have his/her records kept confidential
- To correspond by sealed mail with officials of DMH, his/her lawyer, or a court
- Unless otherwise stated by law, to have the same legal rights and responsibilities as any other citizen
- To receive an impartial review of alleged violations of the rights listed above and any also otherwise assured under law

**THE CONSUMER IS ALSO ENTITLED TO THE FOLLOWING RIGHTS, WHICH MAY BE LIMITED:**

- To wear his/her own clothes and to keep and use his/her personal possessions
- To keep and spend a reasonable amount of their own money
- To receive visitors of their own choosing at reasonable times
- To have access to their medical and service records
- To use a telephone both to make and receive confidential calls
- To exercise physically and be able to pursue outdoor recreation
- To have access to current newspapers, magazines, and television programs

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I have read and I understand the Resident (Consumer) Rights. Furthermore, I agree to uphold the Rights of each individual, including each Resident (Consumer) Right to Confidentiality.

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Signature

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Date

## Human Right's Quiz

Is it a violation of someone's human rights:

1. If you offer choices to people we support as to what to eat, what to wear, when to eat or when to shower?  Yes  No
2. If you allow people to move about freely in their own home?  Yes  No
3. If you encourage individuals to pursue interests/hobbies of their choice?  Yes  No
4. If you refer to people we support as children or any other "label" that would cause others to think of them as less than a person who has the rights of any citizen of the United States?  Yes  No
5. If you discuss information about them, in front of them, without speaking to them directly?  Yes  No
6. If you conduct your personal business while supporting someone in their home?  
 Yes  No

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Signature

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Date

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Community Specialist

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Date

Non-Criminal statement

I, \_\_\_\_\_, state that as of the date of signing this form I have no convictions of, or  
(Print Name)  
a plea of, guilty to a misdemeanor or felony charge and/or suspended imposition of sentence, and/or suspended execution  
of sentence for any period of probation or parole; as well as no disqualifications on the MO Department of Health and  
Senior Service Family Care Registry. I understand that failure to disclose any of the above information will result in  
sanctions for me and my employer.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Emergency Procedures for Driving

### 1. STRANDED

- Use flashers to alert other drivers. Contact emergency personnel by cell phone if available. If there is no phone available go to the nearest location with phone and/or assistance. Client must NEVER be left alone.

### 2. WEATHER

- High Water: NEVER cross a road with water across it and the road is not visible. If the car becomes stalled exit immediately, get to high ground and contact emergency personnel immediately.

#### Severe Storms:

- Lightening: Stay in the car
- Tornados: pull to the nearest shelter outside of the car- usually a ditch or field.
- Heavy Rain: pull to the side of the road and wait for it to pass and visibility is clearer.
- Fog: Stay home until clear. If it is not possible to stay home, drive slower and keep headlights on and wipers going to clear mist.

### ITEMS TO KEEP IN THE CAR

- First aid kit
- Jumper cables
- Blanket
- Water
- Tire repair/changing equipment
- Flashlight

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Specialist

\_\_\_\_\_  
Date

## Safe Driving Quiz

1. Am I liable for speeding and/or any other violation of the law while supporting an individual? \_\_\_\_\_

2. What is my back-up plan in case of an emergency, or if I am stranded on the road?

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3. In case of severe storms, tornados, heavy fog, what actions would you take? \_\_\_\_\_

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4. My tires are in good condition, maintenance is performed on a regular basis, my vehicle is insured and I have met all safety inspections by the state of Missouri? \_\_\_\_\_

5. List the basic safety equipment needed in a vehicle:

a) \_\_\_\_\_

d) \_\_\_\_\_

b) \_\_\_\_\_

e) \_\_\_\_\_

c) \_\_\_\_\_

f) \_\_\_\_\_

6. Is it appropriate at any time to leave a supported individual in the vehicle for any amount of time?

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7. I have read the policy on driving individuals in my car? \_\_\_\_\_

Staff should obey all speed limits. At railroad crossings, staff who are operating company owned vehicles are required to stop, look and listen before crossing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Specialist

\_\_\_\_\_  
Date

**PLEASE RETAIN THIS COPY FOR YOUR RECORDS AFTER READING**

**Universal Precautions**

Universal precautions require health care workers to assume that all patients are potentially infected with HIV or other blood borne agents, and to use barriers and other protective equipment to prevent parenteral, mucous membrane, and non-intact skin exposure to blood and certain body fluids of all patients.

Proper hand washing was the first infection control measure instituted in hospitals. The primary mode of transmission of infections in a hospital is by touch or "contact".

Blood and body secretions of **all** patients should be considered hazardous. **You** can protect **yourself** by using gloves and barrier equipment. Know where it is and **use** it!!

Staff is cautioned to carry out control measures in an inconspicuous manner maintaining the least "clinical" appearance possible even though control of infection is stressed.

Fundamental to any infection control program is effective *hand washing*.

Hand washing guidelines and infection control measures for various nursing personal care procedures follow.

**All Support Staff will follow universal precautions as outlined above.**

## Universal Precautions Quiz

Answer "True" or "False"

1. Under the Universal Precautions, you should treat everyone's blood and other body fluids as infectious. \_\_\_\_\_
2. Universal precautions do not apply to emergency medical service personnel. \_\_\_\_\_
3. Infectious diseases can be spread through body fluids. \_\_\_\_\_
4. Hand washing is not necessary after removing gloves. \_\_\_\_\_
5. Gloves are needed only if you will be exposed to blood. \_\_\_\_\_
6. Gloves protect against injuries from sharps. \_\_\_\_\_
7. You should cover any broken skin with a bandage or dressing before going on duty. \_\_\_\_\_
8. Sharps should be disposed of in an approved container immediately after use. \_\_\_\_\_
9. If you're exposed to blood or body fluids, you should report the incident only if you should become infected.  
\_\_\_\_\_
10. Contaminated laundry requires special handling procedures.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Community Specialist

\_\_\_\_\_  
Date



**RESTORING HOPE, LLC  
POLICY AND PROCEDURES MANUAL**

Date: \_\_\_\_\_

I, (print name) \_\_\_\_\_, understand that the Policy and Procedures Manual is available for viewing on the Restoring Hope, LLC website ([www.werestorehope.com](http://www.werestorehope.com)), and acknowledge by my signature below, that I am able to access the Policy and Procedures Manual and agree to abide and follow the contents thereof.

\_\_\_\_\_  
Signature

Please note that anyone else over the age of 18 who resides in your home OR is a regular overnight visitor in your home must complete the following **BEFORE** they come in contact with a consumer:

1. FCSR (background check)
2. Abuse & Neglect Training (found on RH website)
3. Confidentiality Agreement
4. Confidentiality Quiz
5. Consumers Rights Agreements

Also, your spouse, family members, or friends who live in your home and who are over the age of 18, who might provide any direct care support (**even for a short period of time**) must also complete and submit **ALL** of the same documentation on the preceding pages that is required by the primary caregiver, including First Aid/CPR training, **in addition to the above.**

**Please sign and date below and return this page with the rest of your application.**

I, (print name) \_\_\_\_\_, understand the requirements listed above and agree to provide the requested documentation or proof of training as required by the Missouri Department of Mental Health. I will also notify Restoring Hope **BEFORE** any individual, other than those already listed on my Family Profile Sheet, comes to live in my home.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Acceptance and Authorization

The undersigned does hereby accept a Limited Liability Company (LLC), which was prepared as an option available to the undersigned, but the undersigned is under no obligation to accept the LLC and regardless of acceptance or rejection, the undersigned owes no attorney fees or filing fees as these fees have been paid by a third party. The undersigned further acknowledges that the LLC is not an asset of the undersigned unless or until the undersigned accepts the LLC by signing hereunder and tendering this document to the third party's attorney, Lyndell N. Beard of the Beard Law Firm, LLC, P.O. Box 903, West Plains, Missouri 65775.

Furthermore, the undersigned does authorize that an employer identification number (EIN) must be obtained for the LLC provided that said EIN be connected to the LLC with the LLC treated by the Internal Revenue Services (IRS) as a disregarded entity.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Print Name \_\_\_\_\_

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Social Security Number \_\_\_\_\_

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(Area Code) Phone Number \_\_\_\_\_

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.		
	2 Business name/disregarded entity name, if different from above <i>Lifecare Services, LLC</i>		
	3 Check appropriate box for federal tax classification; check only <b>one</b> of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ <b>Note.</b> For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶		<input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate
	5 Address (number, street, and apt. or suite no.)		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	6 City, state, and ZIP code		Requester's name and address (optional)
	7 List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

<b>Social security number</b>									
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<b>or</b>									
<b>Employer identification number</b>									
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### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at [www.irs.gov/fw9](http://www.irs.gov/fw9).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.