

STATE OF MAINE
Department of Health and Human Services
Division of Licensing and Regulatory Services

APPLICATION FOR CHILDREN'S RESIDENTIAL FACILITY LICENSURE

Date: _____

APPLICATION IS: New (____) Renewal (____) Add Program/Service (____)

NAME/TITLE OF ADMINISTRATOR/OPERATOR: _____

PHONE: _____ DATE OF BIRTH: _____

NAME OF SECOND APPLICATION (If Applicable):

PHONE: _____ DATE OF BIRTH: _____

ADDRESS: _____

MAILING ADDRESS (If different):

SOCIAL SECURITY # OR EMPLOYER I.D.# _____

CONTACT PERSON/PHONE (If different): _____

NAME OF FACILITY/AGENCY: _____

CORPORATE NAME (If different): _____

ACCREDITATION: Are you accredited? Yes (____) No (____) If yes, please indicate which accrediting agency: _____. How many years have you held that accreditation? _____

CORPORATE ADDRESS: _____

(If different from above) _____

NAME OF BOARD CHAIR: _____

ADDRESS: _____

TYPE OF FACILITY/AGENCY:

Individual Proprietorship: ____

Partnership: ____

Non-Profit Corporation: ____

For-Profit Corporation: ____

Tribal Government: ____

Parent Co-op: ____

Church: ____

Other (describe): _____

CURRENT LICENSES/CERTIFICATES:

Type: _____ Terms: _____ Exp. Date: _____

Type: _____ Terms: _____ Exp. Date: _____

WAIVER / EXCEPTION REQUEST OR RE-REQUEST (If Applicable)

I/We have received and read the rules for the licensing and/or certification process. I/We understand that this application authorizes representatives of the Department and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ascertain that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We further certify that all information contained in this application (including addendum) is complete and accurate.

SIGNATURES REQUIRED:

_____/DATE: _____
Applicant/Operator/Administrator

Type or Print Name

_____/DATE: _____
2nd Applicant (If Applicable Only)

Type or Print Name

_____/DATE: _____
Board President (If Applicable Only)

Type or Print Name

FURTHER INSTRUCTIONS:

1. COMPLETE THE ATTACHED ADDENDUM SPECIFIC TO THE TYPE OF LICENSURE OR CERTIFICATION THAT IS BEING APPLIED FOR.
2. SUBMIT ALL ITEMS REQUESTED IN THE "PLEASE SUBMIT" SECTION OF THE FORM.

**ADDENDUM
APPLICATION FOR – CHILDREN’S RESIDENTIAL FACILITY**

FACILITY POPULATION:

Number of children to be served:_____ Age Range From_____to_____

Capacity of facility:_____ Sex: Male_____ Female_____ Co-Ed_____

SERVICES TO BE PROVIDED BY FACILITY (Check ALL that apply):

Group Home_____	Waiver Foster Home_____
Mental Health Services_____	Alcohol & Drug Treatment_____
School_____	Sex Offender Program_____
Crisis Residential Program_____	Transitional_____
Independent Living Program_____	Diagnosis/Assessment_____
Dual Diagnosis Program_____	Staff Secure program_____
Other (Please Describe):_____	

SOURCE OF WATER SUPPLY: Municipal_____ Well_____ Other_____

PLEASE SUBMIT:

1. Completed Application
2. Fire Inspection Form (New Applicant Only)
3. Articles of Incorporation (New Applicant Only)
4. Certificate of Occupancy (New Applicant Only)
5. Lead Test Results (If Applicable-New Applicant Only)
6. Complete Policy Manual (New Applicant Only)
*Include Sample Client File
7. Staff Roster

Send completed application to:

Department of Health and Human Services
DLRS – SHS #11
Behavioral Health Program
41 Anthony Avenue, 2nd Floor
Augusta, ME 04333-0011

Phone: 207-287-9300 Fax: 207-287-9252 TTY: 1-800-606-0215

FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM

FORM MUST BE COMPLETED BY:

1. New Applicants (Complete one form for each site from which you plan to deliver services and return with your application.
2. All applicants (Complete and submit form when you are adding a site, changing your address, or closing a site – KEEP COPY OF FORM FOR YOUR RECORDS).

MAIN SITE:

Agency Name (If Applicable): _____ Date: _____

Operator/Exec. Director: _____ Phone: _____

Address: _____ Contact Person (If Different): _____

BRIEF DESCRIPTION OF SERVICES: _____

AGE RANGE OF CLIENTS SERVED: _____ MAXIMUM CAPACITY: _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks) _____

COMPLETE ONLY IF CHANGE:

New Program/Agency In Process of Licensure _____

Closing Existing Site _____ Address: _____

Adding a New Site _____ Address: _____

Moving Office Site Within Same Building _____

NEW SITE: Date of Expected Move: _____

Contact Person: _____ Phone: _____

Directions (If different from above): _____

STAFF ROSTER – INFORMATION

Please complete information below for all staff members including contractors and consultants. If a staff member must be licensed, please indicate under qualifications. All vacancies must be listed by job title. Copy form and use as many sheets as necessary.

NAME JOB TITLE CREDENTIALS EDUCATION DATE OF BIRTH

SUPERVISOR'S NAME _____ CREDENTIALS _____

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SUPERVISOR'S NAME _____ CREDENTIALS _____

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