

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division – Licensure Bureau
 2401 Colonial Drive, PO Box 202953
 Helena MT 59620-2953
 FAX: (406) 444-1742

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
 ADULT FOSTER CARE HOME APPLICATION**

Initial Application

Renewal Application

Name of Facility: _____

Facility Address: _____ City _____ State/Zip _____

Facility Telephone _____ Other Phone _____ Fax _____

Administrator Name: _____

Total Number of Adults you wish to serve: _____ (<i>Maximum number allowed for adult foster care is 4</i>): Will you be serving: Males only <input type="checkbox"/> Females only <input type="checkbox"/> Both <input type="checkbox"/>
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Application for Licensure is being made to serve:

- Persons with Developmental Disabilities
- Elderly
- Persons with Mental Illness

The Adult Foster Care Home must contact with a licensed mental health center that has an adult foster care endorsement pursuant to ARM 37.106.1906 or have a formal working relationship with a case management team providing mental health services to the resident. Please provide the name of the Mental Health

Center or Case Management Team: _____

Names of Adult Members of Household** and Caregivers / Employees (**not including residents)	Date of Birth	Completed "Personal Statement of Health" Attached?	Release of Information form (ROI) attached?
Names of children under age 18 residing in household			

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Operating Organization

Information on ownership, contract or lease agreement if operated by a person other than the owner:

- If a partnership, firm or association, list every member thereof.**
- If a corporation, list the names and address thereof and the names of its officers.**
- State Affiliated Organization**

NAME

ADDRESS

NAME	ADDRESS

(use additional sheets if necessary)

I certify that all information I have furnished to the Department of Public Health and Human Services is true and correct. This application for a license for an Adult Foster Home is hereby submitted under the provision of Section 50-5-101 through 50-5-208-214, MCA.

Signed: _____ Date _____

Signed: _____ Date _____

Title: _____

Address: _____ City _____ St/Zip _____

Enclose a check, money order or draft payable to the Department of Public Health and Human Services for the License fee of \$20.00. This fee will be deposited in the State Treasury and is Non-refundable.