

STATE OF MONTANA  
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES  
Quality Assurance Division

LICENSE APPLICATION and REAPPLICATION FOR YOUTH CARE FACILITIES

NEW APPLICANT

RENEWAL APPLICANT

NAME OF CORPORATION OR AGENCY: \_\_\_\_\_

NAME OF HOME/FACILITY: \_\_\_\_\_

CORPORATION MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: MT ZIP CODE: \_\_\_\_\_

RESIDENTIAL ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: MT ZIP CODE: \_\_\_\_\_

CORPORATION/AGENCY TELEPHONE: \_\_\_\_\_

HOME/FACILITY TELEPHONE: \_\_\_\_\_

EXECUTIVE DIRECTOR: \_\_\_\_\_

FACILITY DIRECTOR/MANAGER: \_\_\_\_\_

Type of Home or Agency to be Licensed. Please check each that applies.

- |   |                                   |                                       |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Youth Group Home             | No. of Beds: <input type="text"/> | No. of Bedrooms: <input type="text"/> |
| <input type="checkbox"/> Therapeutic Youth Group Home | No. of Beds: <input type="text"/> | No. of Bedrooms: <input type="text"/> |
| <input type="checkbox"/> Youth Shelter Care           | No. of Beds: <input type="text"/> | No. of Bedrooms: <input type="text"/> |
| <input type="checkbox"/> Child Care Agency            | No. of Beds: <input type="text"/> | No. of Bedrooms: <input type="text"/> |
| <input type="checkbox"/> Maternity Home               | No. of Beds: <input type="text"/> | No. of Bedrooms: <input type="text"/> |

Age Range of youth to be served:  Total number of youth to be served:

Number of Males:  Number of Females:

Licensing of Youth Care Facilities is mandatory in accordance with Section 52-2-621 MCA

Please complete both sides of form.

Pursuant to HB 66, the QAD Licensure Bureau estimates that your application for license or license renewal will be processed within 60 days of the Division's receipt of ALL application materials.

PROVIDER: PLEASE CHECK "✓" IF ITEM IS ENCLOSED WITH THIS APPLICATION OR WRITE IN THE DATE WHEN THE ITEM HAS BEEN OR WILL BE SENT TO THE DEPARTMENT.

- | Date or | ✓                        | New Applicant  |
|---------|--------------------------|--|
| _____   | <input type="checkbox"/> | Articles of Incorporation, ByLaws or Letter from Sponsoring Board          |
| _____   | <input type="checkbox"/> | Organizational Chart   |
| _____   | <input type="checkbox"/> | Current list of Board of Directors including terms of office and addresses |
| _____   | <input type="checkbox"/> | Plan for Orientation/training of Staff                                     |
| _____   | <input type="checkbox"/> | Grievance procedures staff   |
| _____   | <input type="checkbox"/> | W-9 Taxpayer Identification Form   |
| _____   | <input type="checkbox"/> | Program Description  |
| _____   | <input type="checkbox"/> | Program Policy/Procedures  |
| _____   | <input type="checkbox"/> | Personal Statement of Health CRL-005 (one for each staff member)           |
| _____   | <input type="checkbox"/> | *Certification from Sanitarian   |
| _____   | <input type="checkbox"/> | *Certification from Fire Marshal   |
| _____   | <input type="checkbox"/> | Criminal Background Check Pursuant to ARM 37.97.140                        |
| _____   | <input type="checkbox"/> | Child Protection Background Checks Pursuant to ARM 37.97.140               |
| _____   | <input type="checkbox"/> | Verification of Insurance Pursuant to ARM 37.97.190                        |
| _____   | <input type="checkbox"/> | Floor Plan/Square Footage report   |
| _____   | <input type="checkbox"/> | Job Descriptions   |

- | Date or | ✓                        | Renewal Applicant  |
|---------|--------------------------|--|
| _____   | <input type="checkbox"/> | Major changes to Articles of Incorporation or Bylaws                       |
| _____   | <input type="checkbox"/> | Organizational Chart   |
| _____   | <input type="checkbox"/> | Job Description  |
| _____   | <input type="checkbox"/> | Program Description  |
| _____   | <input type="checkbox"/> | Program or Personnel policy  |
| _____   | <input type="checkbox"/> | Grievance Procedures   |
| _____   | <input type="checkbox"/> | Current list of Board of Directors including terms of office and addresses |
| _____   | <input type="checkbox"/> | Personal Statement of Health CRL-005 (one for each staff member)           |
| _____   | <input type="checkbox"/> | *Certification from Sanitarian   |
| _____   | <input type="checkbox"/> | *Certification from Fire Marshal   |
| _____   | <input type="checkbox"/> | Criminal Background Check Pursuant to ARM 37.97.140                        |
| _____   | <input type="checkbox"/> | Child Protection Background Checks Pursuant to ARM 37.97.140               |
| _____   | <input type="checkbox"/> | Verification of Insurance Pursuant to ARM 37.97.190                        |

\*This is not an Administrative Rule for Youth Care Facilities, however providers are strongly encouraged to obtain these certification to assure an environmentally safe facility.

I certify that all information I have furnished to the Department of Public Health and Human Services is true and correct.

Signature: \_\_\_\_\_

DATE: \_\_\_\_\_