



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

LICENSE APPLICATION and REAPPLICATION PRIVATE ALTERNATIVE ADOLESCENT RESIDENTIAL OR OUTDOOR PROGRAMS

NEW APPLICANT

RENEWAL APPLICANT

NAME OF CORPORATION OR AGENCY: _____

NAME OF PROGRAM: _____

MAILING ADDRESS: _____ CITY _____ ZIP CODE _____

RESIDENTIAL ADDRESS: _____ CITY _____ ZIP CODE _____

(IF MORE THAN ONE LOCATION ATTACH ADDITIONAL SHEET LISTING ALL ADDRESSES OF ALL LOCATIONS AND FACILITIES WHERE PROGRAM SERVICES TO PARTICIPANTS ARE OR WILL BE PROVIDED INCLUDING HOUSING, EDUCATIONAL, THERAPUETIC AND WORK SITE LOCATIONS)

CORPORATION/AGENCY TELEPHONE: _____

PROGRAM TELEPHONE: _____

NAME OF EXECUTIVE DIRECTOR: _____

NAME OF PROGRAM DIRECTOR: _____

NAME OF PROGRAM MANAGER: _____

Type of Program to be licensed. Please check each that applies.

- | | | | |
|--------------------------|-----------------------------|-------------------|-----------------------|
| <input type="checkbox"/> | Residential Program | No. of Beds _____ | No. of Bedrooms _____ |
| <input type="checkbox"/> | Residential Outdoor Program | No. of Beds _____ | No. of Bedrooms _____ |
| <input type="checkbox"/> | Outdoor Program | No. of Beds _____ | No. of Bedrooms _____ |

Age range of adolescents to be served: _____ Total number of adolescents to be served _____

Number of Males _____

Number of Females _____

Licensing of Private Alternative Adolescent Residential or Outdoor Programs is mandatory in accordance with 52-2 MCA.

Please complete both sides of form.

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	Date or ✓	Renewal Applicant
_____	Articles of Incorporation, Bylaws, or Letter from Sponsoring Board	_____	Major changes to Articles of Incorporation or Bylaws
_____	Organizational Chart	_____	Organizational Chart
_____	Current list of Board of Directors including terms of office and addresses	_____	Major changes to Program or Personnel Policy
_____	Previous names, locations, or ownerships	_____	Current list of Board of Directors including terms of office and addresses
_____	Professional Affiliations	_____	Annual Certification from Fire Marshal
_____	W-9 Taxpayer Identification Form	_____	Verification of Insurance
_____	Program Description	_____	Application Supplement/Staff Roster
_____	Program Policy/Procedures		
_____	Certification from Fire Marshal		
_____	Verification of Insurance		
_____	Floor Plan/Square Footage report		
_____	Job Descriptions		
_____	Application Supplement/Staff Roster		

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

Signature: _____ Date: _____

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:

(a) 0-10 participants	\$ 1,688
(b) 11-25 participants	\$ 4,345
(c) 26-50 participants	\$ 8,138
(d) 51 and more participants	\$ 13,313

The fee will be deposited in the State Treasury and is non-refundable.