MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division – Licensure Bureau
2401 Colonial Drive, PO Box 202953
Helena MT 59620-2953
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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:_____
(Maximum number allowed for adult foster care is 4):

Will you be serving: Males only ☐ Females only ☐ Both ☐

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			

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

_____
_____
_____
_____
_____
_____
_____

(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.