STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAB SERVICES
QUALITY ASSURANCE DIVISION

LICENSE APPLICATION/RENEWAL REQUEST
FOR COMMUNITY HOMES FOR PERSONS WITH DEVELOPMENTAL OR PHYSICAL DISABILITIES

_____	_____
Name of Corporation	Name of Community Home
_____	_____
Corporation Mailing Address	Community Home Address
_____	_____
City State Zip Code	City State Zip Code
_____	_____
Corporation Telephone	Community Home Telephone
_____	_ _____
Executive Director	Community Home Manager

License Application for (check one):
( ) Community Home for Persons with Developmental Disabilities
( ) Community Home for Persons with Physical Disabilities

Total Number of Residents _____ Male ( ) Female ( )

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
		Fire Marshal Inspection or date scheduled			**Fire Marshal Inspection or date scheduled**
		Sanitarian Inspection or date scheduled			**Sanitarian Inspection or date scheduled**
		Articles of Incorporation and Bylaws			**Major changes to Articles of Incorporation**
		Organizational Chart			**Major Changes to Organization Chart**
		Copy of Insurance Coverage			**Copy of Insurance Coverage**
		Personnel an Program Policies and Job Descriptions for each position			**Major changes to Personnel or Program Policies**
		Board structure and composition with names, addresses and terms of memberships			**Board structure and composition with names, addresses and terms of memberships**

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PLEASE COMPLETE THE FOLLOWING FOR EACH FULL TIME, PART TIME AND RELIEF STAFF MEMBER

Name	Position	Date of Hire	Med. Cert Date	Orientation Hours	Annual Training Hours	Restraint Training Date	First Aid Training Date

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION GIVEN TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ON THIS APPLICATION IS TRUE AND CORRECT.

_____ _____

Executive Director or Manager **Date**