Alaska Department of Health & Social Services New Application

Division of Health Care Services Renewal

Modification of license

**APPLICATION FOR A LICENSE**

**RESIDENTIAL CHILD CARE FACILITY**

**AS 47.32.040 and 7 AAC 50.030**

|  |  |  |  |
| --- | --- | --- | --- |
| **I. IDENTIFYING INFORMATION** | | | |
| Facility Name: | | | Phone: |
| Facility Physical Address: | | | e-mail: |
| Facility Mailing Address: | | | Fax: |
| Administrator’s Name: | | | Phone:  e-mail: |
| Individual or legal entity responsible for operation of the facility: | | | Phone: |
| Mailing Address: | | | e-mail: |
| Type of Business (Check one): | | | |
| Sole Proprietor For-Profit Corporation Unit or Sub-Unit of Government  Partnership Non-Profit Corporation Tribal | | | |
| If applicant is a unit or sub-unit of government, please provide the following information for the Chief Executive Officer. | | | |
| Name: | Title: | | |
| Address: | Phone: | | e-mail: |
| Type of Facility:    \_\_\_\_\_ Residential Child Care Facility \_\_\_\_\_ Residential Psychiatric Treatment Center \_\_\_\_\_Maternity Home | | | |
| **II. ADMISSION AND PROGRAM INFORMATION** | | | |
| SPECIALIZATIONS: (Check any and all that apply) | | | |
| Emergency Shelter Care \_\_\_\_\_ Short Term Prematernal  Emergency Shelter Runaway Children \_\_\_\_\_ Substance Use Treatment  Care for Pregnant and Parenting Adolescents \_\_\_\_\_ Supervised Transitional Living  Wilderness and Adventure Experience Program | | | |
| Age Range: From: to the age of \_\_\_\_ Capacity: \_\_\_\_\_ Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Both | | | |
| **III. REQUIRED ATTACHMENTS TO APPLICATION** | | | |
| Copy of enabling legislation, charter, partnership agreement, constitution or articles of incorporation if applicant is a legal entity.  \_\_\_\_\_ List of phone numbers and electronic address of each person who has ownership and management interest.  Administrator references  \_\_\_\_\_ Administrator education, experience summary  Proof Administrator fingerprints submitted.  \_\_\_\_\_ Proof of provisional background authorization on the Administrator and all individuals living in the facility age 16 and older, excluding residents.  \_\_\_\_\_ Variance request if applicable  Water test results, unless on city water  Copies of information for parents or referral and placement agencies  Operations manual including:  \_\_\_\_\_ Organizational chart  \_\_\_\_\_ Staffing Plan  \_\_\_\_\_ Complete description of the program  All written policies, handbooks and procedures required to operate the facility  Personnel policies (to include job descriptions and evaluations)  \_\_\_\_\_ Any resident rules and activity schedules  All facility forms  Floor plan diagram including dimensions of bedrooms | | | |
| IV. DOCUMENTS REQUIRED PRIOR TO LICENSURE Disaster preparedness and Evacuation plan meeting the requirements of 7 AAC 10.1010 Life and fire safety  Copy of most recent food service permit required by DEC for license capacity 13 and over  Copy of the most recent fire inspection report for license capacity 6 and over | | | |
| I certify that I am the applicant or am authorized to submit this application on behalf of the applicant that is not an individual and that the contents of the application and the information provided with it are true, accurate and complete. | | | |
| Signature | | Title | |
| Printed Name | | Date | |

**NOTE: If this is a renewal application, please provide copies only of those documents that have changed since the last review.**

|  |  |
| --- | --- |
| **HCS USE ONLY** | **RETURN TO:**  Worker/Agency |
| Application initially received on (date)  It was accepted as complete with all documentation on:    Date Licensing Worker Signature | Division of Health Care Services  Residential Licensing  4601 Business Park Blvd, Building K  Anchorage, AK 99503 |