



Family Systems Application

Division of Licensing

Application for: Family child care Adult foster care Family adult day services
 Adult foster care alternate overnight supervision technology

This is a (check one): New application Renewal Application to change existing AFC program

Note: For child foster care, use the commissioner's designated format (One Study)

This information is available in alternative formats to individuals with disabilities by contacting us at (651) 296-3971. TTY users can call through Minnesota Relay at (800) 627-3529. For the Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Attention. If you want free help translating this information, call (651) 431-3850.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم (651) 431-3850 .

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ (651) 431-3850 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite (651) 431-3850 .

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu (651) 431-3850 .

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງ ໂທຣ໌ຫາ (651) 431-3850 .

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu (651) 431-3850 .

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните (651) 431-3850 .

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, wac (651) 431-3850 .

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al (651) 431-3850 .

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi (651) 431-3850 .

LB4-0001 (1-08)

Facility - Identifying information

APPLICANT NAME <i>(Last, first, MI)</i>	OTHER NAMES USED	BIRTH DATE
CO-APPLICANT NAME <i>(Last, first, MI)</i>	OTHER NAMES USED	BIRTH DATE
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

Provider - Identifying information

ORGANIZATIONAL STRUCTURE <i>(Check one)</i>		
<input type="checkbox"/> Government unit	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Owner	<input type="checkbox"/> Managerial official	<input type="checkbox"/> Controlling individual
APPLICANT NAME		BIRTH DATE
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

AUTHORIZED REPRESENTATIVE <i>(Last, first, MI)</i>		BIRTH DATE
STREET ADDRESS (AUTHORIZED REPRESENTATIVE)		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

Special family child care home - Identifying information

ORGANIZATIONAL STRUCTURE <i>(Check one)</i>		
<input type="checkbox"/> Employer	<input type="checkbox"/> Church	<input type="checkbox"/> Nonprofit
<input type="checkbox"/> Community collaborative		
NAME (EMPLOYER, CHURCH AND/OR COMMUNITY COLLABORATIVE)		CONTACT PERSON <i>(Last, first, MI)</i>
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

Dwelling information *(Check all that apply)*

- Owned Rented Single family house Mobile home
 Multi-unit Attached garage Basement Wood burning stove or fireplace
 Second floor Above second floor

Previous licensure

Are you currently or have you been licensed? Yes No

TYPE OF LICENSE <i>(Check all that apply)</i>		
<input type="checkbox"/> Child care	<input type="checkbox"/> Child foster care	<input type="checkbox"/> Adult foster care
<input type="checkbox"/> Family adult day services		
LICENSE NUMBER	COUNTY/AGENCY/STATE	DATES

All children and adults living/working in the dwelling

1. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
2. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
3. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
4. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
5. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
6. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
7. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
8. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE

References- Required at initial licensure only (Nonrelated individuals) Not required for FADS

1. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

2. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

3. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

For family child care

Class of license <i>(Check one)</i>	Total children including own				
	Adult	Total capacity	Max under school age	Max Toddler/infants	Max number infants
<input type="checkbox"/> A-Family	1	10	6	3	2
<input type="checkbox"/> B1-Family (Spec Inft & T)	1	5	3	3	3
<input type="checkbox"/> B2-Family (Spec Inft & T)	1	6	4	4	2
<input type="checkbox"/> C1-Group Family	1	10	8	3	2
<input type="checkbox"/> C2-Group Family	1	12	10	2	1
<input type="checkbox"/> C3-Group Family	2	14	10	4	3
<input type="checkbox"/> D-Group (Spec Inft & T)	2	9	7	7	4

Hours of operation

Open from the month of: _____ through the month of: _____

Hours for the day of:

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

For adult foster care

TYPE OF CLIENT PREFERRED *(check all that apply):*

Developmentally disabled
 Physically handicapped
 Chemically dependent
 Mentally ill
 Elderly

GENDER	LICENSED CAPACITY
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either	

Alternate overnight supervision technology applicants complete this section.

RESPONSE ALTERNATIVE

1 *(One)* 2 *(Two)*

LEAD COUNTY CONTRACT MANAGER <i>(name/county)</i>	PHONE
HOST COUNTY <i>(service site)</i> CONTRACT MANAGER <i>(if different than above)</i> <i>(name/county)</i>	PHONE

Please submit documentation of items required on the Adult Foster Care Alternate Overnight Supervision Technology Checklist, DHS-5909.

For family adult day services

LICENSED CAPACITY

Hours of operation

Hours for the day of:

Monday _____	Friday _____
Tuesday _____	Saturday _____
Wednesday _____	Sunday _____
Thursday _____	

Applicants for a residential program (adult foster care) license issued by the Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to inquire about applicable local ordinance requirements.

The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Please document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE NUMBER

The information that I have provided on this application is true and accurate. If the commissioner of Human Services grants me a license, I agree to comply with the requirements contained in Minnesota Rules and Statutes at all times during the term of the license. I agree that the commissioner's representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect my home and its grounds at any time during the hours that I provide care. Further, I agree that the documentation and inspection required by the rules is necessary for the commissioner to determine whether I am complying with Minnesota Rules and Laws.

Finally, I agree that any documentation that I provide or representations that I make to the commissioner's representative during the time that I am licensed will be true and accurate and that any misrepresentations or other violations of Minnesota Rules and Laws may result in immediate suspension or revocation of the license.

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF CO-APPLICANT	DATE