DHS-0250-ENG 4-08

Family Systems Application

Division of Licensing

Application for: ☐ Family child care ☐ Adult foster care ☐ Family adult day services

This is a (check one): ☐ New application ☐ Renewal

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 3850-431 (651) .

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ 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. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງໂທຣ໌ຫາ (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 nầy miễn phí, xin gọi (651) 431-3850.

LB4-0001 (1-08)

Facility - Identifying information

APPLICANT NAME *(Last, first, MI)*	OTHER NAMES USED	BIRTH DATE
CO-APPLICANT NAME *(Last, first, MI)*	OTHER NAMES USED	BIRTH DATE

STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE *(9-digit)*

Provider - Identifying information

ORGANIZATIONAL STRUCTURE (*Check one)*

☐ Government unit ☐ Partnership ☐ Corporation ☐ Business entity

☐ Owner ☐ Managerial official ☐ Controlling individual

APPLICANT NAME		BIRTH DATE
STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE *(9-digit)*

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

Special family child care home - Identifying information

ORGANIZATIONAL STRUCTURE (*Check one)*

☐ Employer ☐ Church ☐ Nonprofit ☐ Community collaborative

NAME (EMPLOYER, CHURCH AND/OR COMMUNITY COLLABORATIVE)	CONTACT PERSON *(Last, first, MI)*	
STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE *(9-digit)*

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 *(Check all that apply)*

☐ Child care ☐ Child foster care ☐ Adult foster care ☐ Family adult day services

LICENSE NUMBER	COUNTY/AGENCY/STATE	DATES

All children and adults living/working in the dwelling

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

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

1. NAME *(Last, first, MI)*		
STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE

2. NAME *(Last, first, MI)*		
STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE

3. NAME *(Last, first, MI)*		
STREET ADDRESS	TELEPHONE NUMBER	
CITY	STATE	ZIP CODE

For family child care

Class of license *(Check one)*		Total children including own				
	Adult	Total capacity	School age	Total under school age	Toddler/ infants	Max number Toddler/infants
☐ A-Family	1	10	4	6	3	3 or 2
☐ B1-Family (Spec Inft & T)	1	5	2	3	3	3 or 2
☐ B2-Family (Spec Inft & T)	1	6	2	4	4	4 or 2
☐ C1-Group Family	1	10	2	8	3	3 or 2
☐ C2-Group Family	1	12	2	10	2	2 or 1
☐ C3-Group Family	2	14	4	10	4	4 or 3
☐ D-Group (Spec Inft & T)	2	9	2	7	7	7 or 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 ____________________

Special family child care information

☐ Church care ☐ Employer care ☐ Community collaborative ☐ Not-for-profit

For adult foster care

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

☐ Developmentally disabled ☐ Physically handicapped ☐ Chemically dependent

☐ Mentally ill ☐ Elderly

GENDER

☐ Male ☐ Female ☐ Either

LICENSED CAPACITY

For family adult day services

LICENSED CAPACITY

Hours of operation

Hours for the day of:

Monday	______________________	Friday	______________________
Tuesday	______________________	Saturday	______________________
Wednesday	______________________	Sunday	______________________
Thursday	______________________		

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

Agency use only

Date returned to agency _______/_______/_______

BGS sent _______/_______/_______

Fire inspection requested _______/_______/_______

Attended orientation _______/_______/_______