



**STATE OF MAINE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MAINE CENTER FOR DISEASE CONTROL AND PREVENTION  
DIVISION OF ENVIRONMENTAL AND COMMUNITY HEALTH**

**Children's Licensing**  
Children's Residential Facility Application

<b>SECTION 1: Facility Information</b>			
Facility/Agency Name:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: (     )		Fax No.: (     )	
Email Address:		Social Security No or State Tax ID:	

<b>SECTION 2: Application Type</b>	
<b>APPLICATION FOR CHILDREN'S RESIDENTIAL FACILITY PROGRAM</b>	
License Type (Select all that apply):	
<input type="checkbox"/> New License	<input type="checkbox"/> Renewal License - <b>License #:</b> _____
<input type="checkbox"/> Add a new Service	
<input type="checkbox"/> Group Home	<input type="checkbox"/> Mental Health Services <input type="checkbox"/> School
<input type="checkbox"/> Crisis Residential Program	<input type="checkbox"/> Dual Diagnosis Program <input type="checkbox"/> Independent Living Program
<input type="checkbox"/> Waiver Foster Home	<input type="checkbox"/> Alcohol & Drug Treatment <input type="checkbox"/> Sex Offender Program
<input type="checkbox"/> Transitional	<input type="checkbox"/> Diagnosis / Assessment <input type="checkbox"/> Staff Secure Program
<input type="checkbox"/> Other (Please describe): _____	
<input type="checkbox"/> Add a new Site	

*For questions regarding this program and/or application, please contact the following:*

**Department of Health and Human Services  
Maine Center for Disease Control  
Division of Environmental and Community Health  
Child Care Licensing Unit  
286 Water St., 3<sup>rd</sup> Floor  
11 State House Station  
Augusta, ME 04333-0011**

Tel: (207) 287-5020      Fax: (207) 287-9304      Toll Free: 1-800-791-4080      TTY users call Maine relay 711  
Email: [info.dhhs@maine.gov](mailto:info.dhhs@maine.gov)

<i>Office Use Only:</i>			
Check# _____	MO # _____	Amount \$ _____	Initials: _____ License# _____

SECTION 3: Facility Contact Information			
Name and Title of Primary Contact Person:			
Telephone No.: (      )	Email Address:		
Name and Title of Second Applicant (if applicable):			
Telephone No.: (      )	Email Address:		
Name and Title of Board Chair:			
Telephone No.: (      )	Email Address:		
Corporation Name (if applicable):			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: (      )	Fax No.: (      )		

SECTION 4: Facility Information		
<b>Current Licenses / Certificates.</b> List any licenses currently held:		
Type	Terms	Expiration Date
_____	_____	_____
_____	_____	_____
<b>Type of facility:</b>		
<input type="checkbox"/> Individual Proprietorship	<input type="checkbox"/> Non-Profit Corporation	<input type="checkbox"/> Tribal Government
<input type="checkbox"/> Church	<input type="checkbox"/> Partnership	<input type="checkbox"/> Parent Co-Op
<input type="checkbox"/> Other (describe): _____		
<b>Source of Water Supply:</b>		
<input type="checkbox"/> Municipal	<input type="checkbox"/> Well	<input type="checkbox"/> Other: _____
<b>Services:</b>		
Number of Children to be served: _____	Age Range From _____ to _____	
Capacity of facility: _____	Sex: Male _____	Female _____ Co-Ed _____
Residential License: (Check each component to be reviewed)		
<input type="checkbox"/> Group Home	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> School
<input type="checkbox"/> Crisis Residential Program	<input type="checkbox"/> Dual Diagnosis Program	<input type="checkbox"/> Independent Living Program
<input type="checkbox"/> Waiver Foster Home	<input type="checkbox"/> Alcohol & Drug Treatment	<input type="checkbox"/> Sex Offender Program
<input type="checkbox"/> Transitional	<input type="checkbox"/> Diagnosis / Assessment	<input type="checkbox"/> Staff Secure Program
<input type="checkbox"/> Other (Please describe): _____		
<b>Waiver Request:</b> If you are requesting a new waiver/exception or an extension, please describe your request:		
_____		
_____		
_____		

**SECTION 5: Staff Roster**

Complete the following information. Use additional paper is necessary.

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

**SECTION 6: Submission**

Remember to submit the following documents with your completed application:

- Staff Roster

In addition, first time applicants must also submit:

- Fire Inspection Form (Appendix A)
- Articles of Incorporation
- Certificate of Occupancy
- Lead Test Results (if applicable)
- Complete Policy Manual
- Sample client file

**SECTION 7: Declaration**

I/We have received and read the rules for the licensing and/or certification process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We further certify that all information contained in this application (including Appendix) is complete and accurate.

_____	_____	_____
<b>Print name of Applicant/Operator/Administrator</b>	<b>Signature of Applicant/Operator/Administrator</b>	<b>Date</b>
_____	_____	_____
<b>Print name of 2<sup>nd</sup> Applicant (If Applicable)</b>	<b>Signature of 2<sup>nd</sup> Applicant (If Applicable)</b>	<b>Date</b>
_____	_____	_____
<b>Print name of Board President (If Applicable)</b>	<b>Signature of Board President (If Applicable)</b>	<b>Date</b>

**Fire Inspection Request and Address Change Form**  
**Type of License: CHILDREN'S RESIDENTIAL FACILITY**

**Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.**

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one (1) form for each site from which you plan to deliver services and return with your application. (Complete a separate form for each site).
2. All Applicants: Complete and submit form when you are adding a new site, changing your address, or closing a site. (Retain a copy of this form for your records).

MAIN SITE:

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

Operator/Executive Director: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Person (if different): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

(City, State, Zip)

Phone: \_\_\_\_\_

Description of Services: \_\_\_\_\_

\_\_\_\_\_

Age Range of Clients Served: \_\_\_\_\_ Maximum Capacity: \_\_\_\_\_

Directions to Facility: (Be specific with known landmarks.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**COMPLETE ONLY IF CHANGE:**

**Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.**

New Program/Agency In Process of Licensure:  No  Yes, date of submitted application: \_\_\_\_\_

Closing Existing Site Current Address: \_\_\_\_\_

\_\_\_\_\_

Moving Office Site within Same Building \_\_\_\_\_

Adding New Site New Address: \_\_\_\_\_

\_\_\_\_\_

Date of Expected Move: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Directions to Facility: (Be specific with known landmarks.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_