

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

APPLICATION FOR LICENSURE/CERTIFICATION

(SHELTER FOR HOMELESS YOUTH)

DATE: _____

APPLICATION IS: NEW _____ RENEW _____

NAME/TITLE OF ADMINISTRATOR/OPERATOR: _____

PHONE: _____

ADDRESS: _____ MAILING ADDRESS (If different):

SOCIAL SECURITY # OR EMPLOYER I.D#: _____

CONTACT PERSON/PHONE (If different): _____

NAME OF FACILITY/AGENCY: _____

CORPORATE NAME (If different): _____

CORPORATE ADDRESS: _____

(If different from above) _____

NAME OF BOARD CHAIR: _____

ADDRESS: _____

TYPE OF FACILITY/AGENCY:

Individual Proprietorship: ____

Partnership: ____

Non-Profit Corporation: ____

For-Profit Corporation: ____

Tribal Government: ____

Parent Co-op: ____

Church: ____

Other (describe): _____

ACCREDITATION: Are you accredited? Yes (____) No (____) If yes, please indicate

which accrediting agency: _____ . How many years have you

held that accreditation? _____

CURRENT LICENSES/CERTIFICATES:

Type: _____ Terms: _____ Exp. Date: _____

Type: _____ Terms: _____ Exp. Date: _____

WAIVER/EXCEPTION REQUEST OR RE-REQUEST (If Applicable): DESCRIBE:

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 and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ascertain that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain any criminal or protective records information which may be on file in any county, state or federal office.

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

SIGNATURES REQUIRED:

_____/DATE: _____
Applicant/Operator/Administrator

Type or Print Name

_____/DATE: _____
Board President

Type or Print Name

FURTHER INSTRUCTIONS:

1. COMPLETE THE ATTACHED ADDENDUM SPECIFIC TO THE TYPE OF LICENSURE OR CERTIFICATION THAT IS BEING APPLIED FOR.
2. SUBMIT ALL ITEMS REQUESTED IN THE "PLEASE SUBMIT" SECTION OF THE FORM.

ADDENDUM
APPLICATION FOR – SHELTER FOR HOMELESS

FACILITY POPULATION:

Capacity of Facility: _____ Age Range: From _____ To _____

Sex: Male Only: _____ Female Only: _____ Co-Ed: _____

SOURCE OF WATER:

Municipal: _____ Private: _____ Other: _____

PLEASE SUBMIT:

1. Completed Application
2. Articles of Incorporation (New Applicants Only)
3. Budget
4. Fire Inspection Form (New Applicants Only)
5. Policy Manual (New applicants Only)

SUBMIT TO:

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

Phone: 207-287-8016 Fax: 207-287-9304 TTY: 1-800-791-4080

FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM

Type of License/Certificate: _____

FORM MUST BE COMPLETED BY:

1. New Applicants (Complete one form for each site from which you plan to deliver services and return with your application. *NEED ONE FORM FOR EACH SITE.*)
2. All Applicants (Complete and submit form when you are adding a site, changing your address, or closing a site – KEEP COPY OF FORM FOR YOUR RECORDS.)

MAIN SITE:

Agency Name (If Applicable): _____ Date: _____

Operator/Exec. Director: _____ Phone: _____

Address: _____ Contact Person (If different): _____

BRIEF DESCRIPTION OF SERVICES: _____

AGE RANGE OF CLIENTS SERVED: _____ MAXIMUM CAPACITY: _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks) _____

COMPLETE ONLY IF CHANGE:

New Program/Agency In Process of Licensure _____

Closing Existing Site _____ Address: _____

Adding a New Site _____ Address: _____

Moving Office Site Within Same Building _____

NEW SITE: Date of Expected Move: _____

Contact Person: _____ Phone: _____

WATER SOURCE: Municipal _____ Well _____ Other _____

Directions (If different from above): _____