



**STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Workforce Development Program
Placement Agency Application**

SECTION 1: Provider Information			
Agency Name:			
Doing Business As:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Email Address:			

SECTION 2: Fees	
APPLICATION FOR A PLACEMENT AGENCY	
License Type: <input type="checkbox"/> New License (fee \$25) <input type="checkbox"/> Renewal License (fee \$25)	
Total Fee Enclosed for application	\$ <u>25.00</u>
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. Application fees are non-refundable.	
Total Check/Money Order enclosed: =	\$ <u>25.00</u>

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

Department of Health and Human Services
 Licensing and Regulatory Services
 Workforce Development Program
 41 Anthony Ave
 11 State House Station
 Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-5807 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
 Email: info.dhhs@maine.gov

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

SECTION 3: Ownership Information (Use additional sheets, if necessary)

Owner Name:

Mailing Address:

City:

State:

Zip:

County:

Telephone No.: ()

ID# (Owner SSN or EIN#):

Type of Entity: Sole Proprietorship (complete section A) Corporation (complete section C) Partnership (complete section B) Not-for-Profit (complete section D) Other: _____

Fiscal Year End Date: _____

A. Sole Proprietorship

Owner Name:

Mailing Address:

City:

State:

Zip:

County:

Telephone No.: ()

ID# (Owner SSN or EIN#):

B. Partnership

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name

Address

_____	_____
_____	_____
_____	_____

C. Corporation

List the names, address and titles of the Officers and Directors.

Officer's Name

Title

Address

_____	_____	_____
_____	_____	_____
_____	_____	_____

Director Name

Title

Address

_____	_____	_____
_____	_____	_____
_____	_____	_____

Shareholder's Name

Title

Address

_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Not-for-Profit

List the name and address of the Board of Directors President or the appropriate Municipal Government Representative.

Name

Address

_____	_____
_____	_____

SECTION 4: Facility Information (Use additional sheets, if necessary)

Name of Administrator:

Title:

Home Address:

City:

State:

Zip:

County:

Home Telephone No.: ()

Office Telephone No.: ()

Services Provided: Select all that apply.

- Long Term Care
 Acute Care
 Psychiatric
 Home Health Agency
 Other: _____

Estimate the number of personnel to be placed during the next 12 months: _____

List the types of health care personnel available from your agency:

1. _____
2. _____
3. _____
4. _____

SECTION 4: Declaration

- The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

Print name of Administrator_____
Signature of Administrator_____
Date