

**MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
MEDICAL FACILITIES UNIT**

**APPLICATION FOR RELICENSURE OF
AN INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION**

Name of Facility:	_____			
Physical Location:	_____			
	(Street/Road)	(City/Town)	(Zip)	(County)
Mailing Address, if different:	_____			
Telephone Number:	_____	Fax Number:	_____	

Name of Administrator:	_____		
Administrator License #:	_____	Expiration Date:	_____
Business address and telephone number of Administrator, if different from facility address:	_____		
	_____	Telephone Number:	_____

Number and location of beds for each level of care:		
	<u># of Beds</u>	<u>Location (Building, Ward, Wing, Floor)</u>
ICF/MR Group Beds:	_____	_____
ICF/MR Nursing Beds:	_____	_____

Description of all structures and facilities forming any part of this institution:

Utilities:
Water Supply: <input type="checkbox"/> Public <input type="checkbox"/> Private (If private, include copy of last water report)
Sewage Disposal: _____

Name of Director of Nursing:	_____
Name of Medical Advisor/Director:	_____

Licensure fee:

\$10.00 per bed. Please make your check or money order payable to the Treasurer, State of Maine, and mail it to:

Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby apply for a license to operate the facility and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services.

(Name of Administrator – Printed)

(Signature of Administrator)

(Date)

(Name of Owner [if different from above] – Printed)

(Signature/Title)

(Date)