

Maine Department of Health and Human Services
DIVISION OF LICENSING AND REGULATORY SERVICES
MEDICAL FACILITIES UNIT

Application for Licensure / Relicensure of a Level IV Residential Care Facility

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

Name of Administrator: _____
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Facilities licensed for 6 beds or less:	
How many employees (full and part-time) work at the facility?	_____
Additions/renovations to facility:	_____ _____
Other changes to the facility:	_____ _____
Does the facility have a waiver?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, indicate Item # and reason below) _____
Does the waiver still apply?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever:	
Been convicted of a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been investigated for child/adult abuse, neglect or exploitation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had a license/application to operate an assisted living facility revoked/denied/placed on conditional status?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

The applicant certifies that information contained in this reapplication is true and correct to the best of his/her knowledge. The Department of Health and Human Services reserves the right to determine the suitability of the applicant for relicensure.

I, _____, being duly authorized to assume responsibility for the conduct of the institution herein described, do hereby apply for relicensure 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, as authorized by Title 22, M.R.S.A. §7802.

(Name of Administrator – Printed)

(Signature of Administrator)

(Date)

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

(Signature of Owner, if different from above)

(Date)