



STATE OF MICHIGAN

DEPARTMENT OF HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
INTERIM DIRECTOR

RE: ADULT FOSTER CARE FAMILY HOME APPLICATION

Dear Applicant:

The following is information regarding application for an adult foster care family home for 6 or less. Your application for licensure will not be considered complete until you have demonstrated compliance with all applicable licensing requirements. Instructions and additional materials are included to assist you in completing the application.

Please return all of the completed and required application materials with a check or money order (which is non-refundable) payable to the "**State of Michigan**" in the amount of \$65.00 to:

Michigan Department of Human Services
Cashier's Office
P.O. Box 30759
Lansing MI 48909-8259

Please note that once you have submitted your application you may not add or delete a licensee name from the application or change the facility type you have indicated on your application. These changes require that you submit a new application and a new fee. **Fees are non-transferable**. When a new application is required, fees previously submitted cannot be credited to the new application.

It is therefore strongly recommended that you contact the local field office and speak with a licensing consultant prior to submitting your application and fee to assure that you are submitting the correct application, for the correct facility type, with the appropriate licensee name. You may find the local field office listing online at http://www.michigan.gov/dhs/0,4562,7-124-5455_27716_27717-80929--,00.html.

For additional information, please contact the Licensing Unit at 866-685-0006 or Fax at (517) 284-9709.

Thank you.

Enclosure

Adult Foster Care Inquirer & Applicant Assistance

In an effort to better serve Adult Foster Care (AFC) inquirers and applicants, the Bureau of Children and Adult Licensing (BCAL) offers application assistance. There is an online tutorial on our website located at:

http://www.michigan.gov/dhs/0,1607,7-124-5455_27716_27717---,00.html. Field office staff also provides this assistance; some may present this information in a group-meeting format.

The information provided on the website or by individual local office staff:

- Presents an overview of the licensing application process
- Is intended to assist you in making an informed decision about applying for an AFC license
- Is intended to assist you in identifying the type of license application to complete and the category of AFC facility you wish to apply.

You are encouraged to review the online tutorial and/or contact your assigned BCAL field office **before submitting an application**. Please review the [BCAL AFC office area coverage list](#), find the county where the proposed facility will be located, and contact the assigned BCAL field office indicated for application assistance.

The following BCAL field offices provide individual one on one information meetings; you must call the assigned office for an appointment: Escanaba, Flint, Grand Rapids, Jackson, Lansing, Marquette, Midland, Saginaw and Traverse City.

The Detroit BCAL field office provides group information meetings; you must call 313-456-0380 for an appointment.

**ORIGINAL APPLICATION INSTRUCTIONS
ADULT FOSTER CARE FAMILY HOMES
1-6 RESIDENTS**

This instruction sheet specifies forms and information that must be completed and submitted before an on-site inspection can be conducted or a license can be issued.

The Family Home licensee(s) is required to be a member of the household and an occupant of the residence. A Family Home license cannot be issued to a corporation or limited liability company. Compliance with [1979 PA 218](#), the Adult Foster Care Facility Licensing Act and the Administrative Rules for AFC Family Homes is your responsibility.

Please submit the following:

A. APPLICATION (BCAL-569-I)

Complete all areas; sign and date it.

B. LICENSE APPLICATION FEE

A check or money order in the amount of \$65.00 payable to the "State of Michigan".

PLEASE DO NOT SEND CASH

C. LICENSING RECORD CLEARANCE REQUESTS (BCAL-1326A)

1979 PA 218, Sec 13 (3)(c)(e) requires that an applicant, all employees and all members of the household be of good moral character. The Department will determine compliance for the individuals listed below. In order for the Department to determine compliance, a Licensing Record Clearance Request will need to be completed and submitted for:

- **License Applicant(s)**, as listed on the application.
- **Members of the household, 18 years of age or older, who live in the home and are not foster care residents.** These individuals must be listed on the application.
- **Responsible persons.**

1979 PA 218, Sec. 13(21) requires the applicant, and any co-applicant (if applicable) to submit fingerprints for a criminal history check. (If any of these individuals submitted fingerprints for employment in an adult foster care or home for the aged facility through the Workforce Background Check Program, and have remained continuously employed at that facility since submitting fingerprints, a new fingerprint submission is not required.)

Persons completing this form should **ONLY** complete Section II of the Clearance Request (BCAL-1326A). Return the **completed, signed and dated** forms with your application. If additional forms are needed, please go to www.michigan.gov/afchfa. This information is mandatory. The licensing process will not proceed until this information has been received and the Clearance Request(s) processed by the Licensing Unit.

Additional Documentation You Will Need To Provide to the Consultant and Maintain in the Home:

- _____ **R 400.1405 (2) Medical Clearance Request or equivalent.** You must provide a Medical Clearance Request (BCAL 3704-AFC), or its equivalent, completed by a licensed physician or their designee for each license applicant and each responsible person. It cannot be dated more than 6 months prior to license issuance. It is recommended that you do not have the Medical Clearance Request completed until you speak to a consultant.

- _____ **R 400.1405 (3) Tuberculosis.** You must provide written evidence that each license applicant and responsible person is free from communicable tuberculosis.

- _____ **R 400.147 (10) House guidelines.** If you intend to have resident house guidelines, you will need to submit them to your consultant for review and approval.

- _____ **R 400.1438 (1) Evacuation Plan.** You will need to develop an evacuation plan and written procedures to be followed in case of fire, medical and severe weather emergency. You will need to submit your evacuation plan to your consultant for review and approval.

- _____ **Section 400.734 (a) Good Moral Character of Employee.** See enclosed.

NOTE: The items above are only some of the required documents and information. Your licensing consultant may ask for additional information as part of the licensure process. **It is your responsibility to review the rules and statutory requirements and demonstrate compliance to the department.** A recommendation for license issuance cannot be made and your application will not be considered complete, until all the items listed above, as well as any requested by your consultant, have been reviewed and approved by the department.

ENVIRONMENTAL HEALTH INSPECTIONS

If you have a well and/or private sewage disposal system, it will need to be inspected by the local county health authority. **The Department will arrange for this inspection.**

Enclosures: BCAL 569-I Application
 BCAL 1326A AFC Licensing Record Clearance Request
 BCAL 3704-AFC Medical Clearance Request
 1979 PA 218
 Administrative Rules for Adult Foster Care Family Homes

**ADULT FOSTER CARE LICENSE
INDIVIDUAL APPLICATION**
Michigan Department of Human Services
Bureau of Children and Adult Licensing

FOR DHS USE ONLY – Cashier Code: 40

License Number:

Paid Amount:

Cashier:

SECTION I – FACILITY INFORMATION

1. Facility Name		2. Application Type <input type="checkbox"/> Original <input type="checkbox"/> Renewal <input type="checkbox"/> Amended			3. License Number	
4. Facility Street Address		5. City/Village		6. Township	7. State	8. Zip Code
9. County	10. Zoning Authority <input type="checkbox"/> Township <input type="checkbox"/> City/Village		11. Telephone Number ()	12. Fax Number ()	13. New Construction <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Proposed Capacity	15. I would prefer: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both		16. Ages	17. Currently Certified As A Specialized Program or Requesting Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Program Type(s) <input type="checkbox"/> Mentally Ill <input type="checkbox"/> Developmentally Disabled <input type="checkbox"/> Aged <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Wheelchair Accessible <input type="checkbox"/> Physically Handicapped <input type="checkbox"/> Traumatic Brain Injured				19. Water System <input type="checkbox"/> Public <input type="checkbox"/> Private		20. Sewer System <input type="checkbox"/> Public <input type="checkbox"/> Private
21. Facility Type <input type="checkbox"/> Family Home 1-6 <input type="checkbox"/> Small Group 1-6 <input type="checkbox"/> Small Group 7-12 <input type="checkbox"/> Large Group 13-20 <input type="checkbox"/> Congregate 21 or more – EXISTING ONLY						

SECTION II – APPLICANT LICENSEE INFORMATION

All original applicants must complete a Licensing Record Clearance Request form.

22. Applicant Name		23. Social Security	Federal Tax ID Number	24. Date of Birth	
25. E-mail Address		26. Telephone Number ()		27. Fax Number ()	
28. Street Address			29. City	State	Zip Code
30. Mailing Address, if different (i.e. P.O. Box)			City	State	Zip Code
31. Joint Applicant Name (if applicable)		32. Social Security	Federal Tax ID Number	33. Date of Birth	
34. E-mail Address		35. Telephone Number ()		36. Fax Number ()	
37. Street Address			38. City	State	Zip Code
39. Mailing Address, if different (i.e. P.O. Box)			City	State	Zip Code

SECTION III – RESPONSIBLE AGENCY INFORMATION (If Applicable) Attach Additional sheets, if necessary

40. Agency Name and Address	41. Name of Contact Person	42. Telephone Number

SECTION IV – ADMINISTRATOR or RESPONSIBLE PERSON INFORMATION

Administrators must complete a Licensing Record Clearance Request form.

43. Group Home/Congregate Applicants. Print Name of Person Responsible for Daily Operation of the Facility (Administrator)	Date of Birth	Social Security Number
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44. FAMILY HOME APPLICANTS ONLY: Provide the name(s) of at least one responsible adult, other than the applicant or joint applicant, who can provide up to 72 hours of emergency coverage for you. Responsible persons must have proof of current T.B. test results and a physician's statement that they are both physically and mentally capable of caring for and being around residents.

Name (Last, First, Middle)	Date of Birth	Social Security No.	Street Address (city, state and zip)	Telephone Number

45. Describe any convictions of the applicant, joint applicant, administrator, and non-employee adult members of the household. Do not include minor traffic violations.

46. Has the applicant or joint applicant now, or ever, operated an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 48. Yes No

47. Have you ever been denied a license to operate an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, child placing agency, or adult or children's camp? If "yes" please complete Item 48. Yes No

48. If "YES" to either Item 47-48, complete the following information. Include all currently and previously licensed programs and denied license applications. Attach additional sheets, if necessary.

Name of licensing/certifying agency	Type of care	License Number	Application Date	Open	Closed

49. Provide the following information for all persons who live in the facility, including relatives, roomers and boarders and live-in staff and children. Do not include adult foster care residents. All non-employee adult household members who are not residents must complete a Licensing Record Clearance Request form. Attach additional sheets, if necessary.

Name (Last, First, Middle)	Position or Relationship	Date of Birth

50. Directions for reaching family from Bureau of Children and Adult Licensing field office.

SECTION V – OWNERSHIP INFORMATION

51. Identify all ownership interest in the business. Include additional sheets if necessary.

NAME	ADDRESS (City, State and Zip Code)

52. Ownership of facility to be licensed: Own Rent/Lease Buying

53. Identify all ownership interest in the property. Include additional sheets, if necessary.

NAME	ADDRESS (City, State and Zip Code)

SECTION VI – FINANCIAL INFORMATION

All questions must be answered by the Applicant and Joint Applicant to the best of his/her knowledge. Attach an explanation for each question answered "Yes."

54. HAS THE APPLICANT OR JOINT APPLICANT EVER:

a. Filed for Bankruptcy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Had a default judgment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Had a seizure of assets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Had a repossession or foreclosure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Had a lien enforced against it?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Had a notice of eviction due to payment problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had financial assets frozen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Had a garnishment or attachment of wages or income?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Had a contract to receive public or private monies not renewed or terminated prior to its expiration?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

55. FOR FAMILY HOME APPLICANTS ONLY:

A. **I have sufficient resources to meet Rule 400.1404(4).** The department defines "sufficient resources as follows:
Original applicants have financial assets available to provide for the operation of the home for a period of at least three months.
Renewal applicants have financial assets available to provide for the operation of the home for a period of at least 30 days.

These resources are from: (check all that apply)

- Applicant/Joint Applicants employment outside of adult foster care
- Non-Applicant/Joint Non-Applicant spouse's income
- Savings or available cash
- Funding contracts/Intent to contract statement
- Adult foster care income
- Other, specify

Please attach an explanation of all items checked. You may be required to provide verification and/or documentation of the financial information provided.

B. I do not have sufficient resources at this time to meet Rule 400.1404(4). *You may submit additional information for consideration.*

Section VII – CERTIFICATION AND SIGNATURES

I have read 1979 PA 218, and the Administrative Rules regulating the operation of Adult Foster Care facilities. If granted a license I will comply with the Act and these Rules.

In order to permit a proper determination of conformity with the rules, I give permission to the Department of Human Services to make all necessary and reasonable investigations of my activities, proposed standards of care, and to make an on-site inspection of the proposed facility.

I am aware of the legal provisions of Section 13 and Section 31 of 1979 PA 218, respectively, that operating an adult foster care facility without a license or to violate this Act is subject to criminal penalties, punishable by imprisonment or a substantial fine or both.

I certify that I will assess the good moral character of the employees of this home/facility, as required by PA 218. I certify that if I or any employee, volunteer, or household member of the facility who is on parole or probation or convicted of a felony will be reported to the Department.

I also certify that any information I give in respect to any investigation by the department will be, to the best of my ability, true and correct.

I give permission to the Michigan Department of Human Services to contact persons, including those I give as references, in order to determine if I am in compliance with the Act and the Rules.

56. Applicant Name (print or type)	57. Applicant Signature	58. Date
59. Joint Applicant Name (print or type)	60. Joint Applicant Signature	61. Date

AN APPLICATION FEE (which is non-refundable and non-transferable), payable by check or money order **ONLY**, to the **STATE OF MICHIGAN**, is to be sent in accordance with the Application Instructions. The fees are:

	<u>ORIGINAL</u>	<u>RENEWAL</u>		<u>ORIGINAL</u>	<u>RENEWAL</u>
Family Home 1 – 6	\$ 65.00	\$25.00	Large Group Home 13 – 20	\$170.00	\$100.00
Small Group Home 1 – 6	\$105.00	\$25.00	Congregate Facility 21+	\$220.00	\$150.00
Small Group Home 7 – 12	\$135.00	\$60.00			

<p>Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.</p>	<p>AUTHORITY: 1979 PA 218 COMPLETION: Mandatory NON-COMPLETION: License issuance will be denied</p>
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AFC/HFA LICENSING RECORD CLEARANCE REQUEST INSTRUCTIONS

The purposes of this form are:

1. Verify the address of a family home applicant with Secretary of State records.
2. Produce a Bureau of Children and Adult Licensing (BCAL) files check for a current or previous licensee status of the applicant in any county of the state.
3. Produce a Department of State Police check regarding the possible existence of a conviction record.

Instructions for processing: The Licensing Record Clearance (BCAL-1326A) must be taken with you at the time the FBI fingerprint is conducted. **Note: The TCN# will be filled in by the Fingerprint Specialist and must be completed prior to submitting the form.**

Fingerprint check of Adult Foster Care and Home for the Aged license applicants and others as required by licensing statutes. You may select a fingerprint vendor at www.michigan.gov/msp/0,1607,7-123-1589_1878_8311-237662--,00.html

The existence of a conviction record does not necessarily disqualify an applicant for licensure, or an individual from employment or residents in an adult foster care facility. However, it does provide BCAL with information which will be carefully evaluated by licensing staff. **A failure on the part of an applicant to provide BCAL with accurate and truthful information and the authorization requested on this form may be sufficient cause to deny issuance of a license.**

- I am aware that Michigan Department of State Police Records will be checked for information regarding criminal convictions.
- I certify that the information I have given on the form is, to the best of my ability, true and correct.
- The Department may perform this check at any time while I am licensed or associated with a licensed facility.
- I understand the personal information and fingerprints submitted by live scan are used to search against criminal identification records from both the Michigan State Police (MSP) and Federal Bureau of Investigation (FBI). I hereby authorize the release of any records to the person or agency listed above. I further understand MSP and the FBI may also retain the submitted information and fingerprints as permitted by the Federal Privacy Act of 1974 (5 USC § 552a(b)) for routine uses beyond the principal purpose listed above. Routine uses include, but are not limited to, disclosures to: governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security, or public safety.
- 28 CFR §16.34- Procedure to obtain change, correction or updating of identification records.

If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.

****DISCLAIMER: ALL FINGERPRINTS PROCESSED WITH INCORRECT FINGERPRINT CODES OR USE OF THE WRONG LICENSE RECORD CLEARANCE REQUEST FORM ARE THE RESPONSIBILITY OF THE INDIVIDUAL. MSP WILL CHARGE FOR SECOND REQUESTS DUE TO INCORRECT FINGERPRINT CODES.**

AUTHORITY:	1978 PA 368 1979 PA 218	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
COMPLETION	Required	
CONSEQUENCE:	Licensure may be denied.	

AFC/HFA LICENSING RECORD CLEARANCE REQUEST STATE OF MICHIGAN

Department of Human Services
Bureau of Children and Adult Licensing

DIRECTIONS FOR COMPLETING FORM: <ul style="list-style-type: none"> • Please read the accompanying instructions before completing this form. • Please type or print CLEARLY so that the information provided can be read. • Mail completed form to BCAL Central Office or address noted in box below. 	LIVESCAN FINGERPRINT REQUEST <i>Fingerprint Specialist section only.</i>
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SECTION I: REQUESTOR INFORMATION <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> Department of Human Services Bureau of Children and Adult Licensing 201 North Washington Square P.O. Box 30650 Lansing, MI 48909 </div> Licensing Consultant (if known)	TCN# _____ (MUST BE FILLED IN PRIOR TO RETURNING) Date Fingerprinted: _____ Type of Picture I.D. presented: _____ <input type="checkbox"/> FCL (Adult Foster Care) Agency ID: 86871E <input type="checkbox"/> HAL (Homes for the Aged) Agency ID: 86872L
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Licensee/Applicant Name	Name of Facility	County	BCAL License Number (If assigned)
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License/Application Type (**check all that apply**):

AFC Group Home Home for the Aged
 AFC Family Home

The Person Being Cleared Is (**CHECK ONLY ONE PER FORM**):

Applicant/Co-Applciant Licensee/Licensee Designee Authorized Representative (HFA only)
 Responsible Person (AFC Family Homes Only) AFC Administrator (Responsible for daily operation of group home)
 Adult Member of Household (specify relationship to licensee):
 Other (describe):

SECTION II: CLEARANCE INFORMATION (To be completed by applicant or other person to be cleared – If more than one person is named on the application, each is to complete a BCAL-1326A). PRINT CLEARLY.

NAME (Last, First, Middle Jr., II, etc.)	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER - -
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MARITAL STATUS <input type="checkbox"/> SGL <input type="checkbox"/> MAR <input type="checkbox"/> DIV <input type="checkbox"/> WID	ALSO KNOWN AS (Aliases, Maiden Name, Previous Married Name(s))
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ADDRESS (Street Number and Name)	MICHIGAN DRIVERS LICENSE OR STATE ID NUMBER
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CITY	COUNTY	STATE	ZIP CODE	PHONE NUMBER	RACE	HEIGHT	WEIGHT
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OTHER STATES RESIDED IN DURING PAST 5 YEARS:

Have You Ever Been Convicted Of A Crime, Felony Or Misdemeanor?

NO YES (If yes, explain)
 Type, Location, and Date of Conviction(s)

My signature certifies that I have reviewed the instruction page.

Signature Of Person To Be Cleared	Date
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SECTION III: CENTRAL RECORDS CLEARANCE (BCAL Use Only) SECTION IV: CONVICTION CLEARANCE

PREVIOUS LICENSE? <input type="checkbox"/> NO <input type="checkbox"/> ACTIVE <input type="checkbox"/> CLOSED	INITIALS/CLEARANCE DATE	For BCAL Use Only
LICENSE NUMBER		
DISCIPLINARY ACTION? <input type="checkbox"/> YES		
SECRETARY OF STATE DISCREPANCY? (For family home applicants only)	INITIALS/CLEARANCE DATE	
<input type="checkbox"/> NO <input type="checkbox"/> YES		

MEDICAL CLEARANCE REQUEST – ADULT FOSTER CARE AND HOMES FOR THE AGED

Michigan Department of Human Services
Bureau of Children and Adult Licensing

APPLICANT/LICENSEE INFORMATION

Facility/Home Name		License Number	
Facility/Home Address (Street Number and Name)	City	State	Zip Code

PLEASE MAIL TO →
 Licensing Consultant (Name, Address, Phone)
 Department of Human Services
 Bureau of Children and Adult Licensing
 201 North Washington Square
 P.O. Box 30650
 Lansing, MI 48909

License Application Type
 Adult Foster Care (24-Hour Care)
 Home for the Aged (24-Hour Care)

PATIENT INFORMATION (To be Completed by Patient) (Please Print or Type)

Name (Last, First, Middle, Jr., II, etc.)	Date of Birth	Social Security Number	Telephone Number
Address (Street Number and Name)	City	State	Zip Code

RELEASE OF INFORMATION (To be Completed by Patient)

I authorize the release of medical information concerning me to the facility/home listed above and to the Michigan Department of Human Services, Bureau of Children and Adult Licensing, for the purpose of determining my suitability to provide or be associated with the care of dependent adults.	Date
	Patient's Signature
	Physician's Name (Please PRINT or TYPE)

MEDICAL INFORMATION (To be Completed by Physician)

<ul style="list-style-type: none"> This individual is, or will be, employed in a dependent adult care setting. It is necessary to establish that those providing care are in such physical and mental condition and health as not to adversely affect the health or safety of a dependent adult and the quality and manner of his/her care. To assist us in this determination, you are being asked to answer the following. 			
Has this Person Been Tested for T.B.? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes →	Date Tested	Test Type <input type="checkbox"/> Skin Test <input type="checkbox"/> X-Ray	Results <input type="checkbox"/> Positive (Explain in Comments) <input type="checkbox"/> Negative
How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)			
<input type="checkbox"/> No physical/mental condition or health problem exists that would limit the ability to work with or around dependent adults.			
<input type="checkbox"/> Physical/mental condition or health problem exists that would not limit the ability to work with or around dependent adults. Explain in Comments if reasonable accommodation may be needed.			
<input type="checkbox"/> Physical/mental condition or health problem exists which would affect the ability to work with or around dependent adults, with or without reasonable accommodation.			
Comments (Please use back of this form if additional space is needed.)			
Would you like to be contacted by the licensing consultant regarding your recommendation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Licensed Physician or his/her designee Signature	Signature Date	Telephone Number	Examination Date
Address (Street Number and Name)	City	State	Zip Code
AUTHORITY: 1973 PA 116 1979 PA 218 RESPONSE: Voluntary PENALTY: Application for licensure may be denied.		Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	