

ENVIRONMENTAL HEALTH INSPECTION REQUEST

Michigan Department of Health and Human Services

Division of Child Welfare Licensing

INSPECTIONS: Items 1-21 and 23 to be completed by licensing consultant/worker.
Item 22 to be completed by health inspection agency.

5. Name and Address of the Health Inspection Agency

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| 1. Licensing Number |
| 2. Expiration Date |
| 3. Status of License |
| 4. Please return the completed inspection report by this date |
| Health Department Phone Number |
| Proposed/Current Capacity |

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|---|---|
| 6. Facility Type <input type="checkbox"/> Children's Foster Home | ▶ |
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|--|--|--|--|
| 7. Reason for Inspection | <input type="checkbox"/> Relocation <input type="checkbox"/> Reinspection | <input type="checkbox"/> Renewal Inspection <input type="checkbox"/> Complaint/Other (Specify in No. 8) | |
| <input type="checkbox"/> New Application | | | |

8. Inspection Request (Assessment of compliance with the requirements listed on the reverse side)

Family or Group Foster Home - Private Water Supply - Use BCAL-1788-CWL
 Family or Group Foster Home - Private Sewage Disposal System - Use BCAL-1788-CWL

Compliance Requirements:
Private water supply and/or private sewage disposal systems must meet the requirements of the local or state health department.

Comments: _____

9. Return Completed Inspection Report To:

Division of Child Welfare Licensing
 _____ (Name of Child Placing Agency)

Licensing Consultant's/Worker's Name _____ Telephone Number _____

Address of Licensing Consultant/Worker (Number Street, City, Zip Code) _____

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|--|--------------|-----------------------------|----------------------------|---|
| 10. Name of Facility | | 11. Directions to Facility: | | |
| 12. Administrator/Contact Person | | | | |
| 13. Address of Facility (Number, Street) | | 14. City | 15. Township | |
| 16. County | 17. Zip Code | 18. Facility Phone Number | 19. Alternate Phone Number | 20. Date of Last Environmental Health Insp. |

21. The Michigan Department of Human Services authorizes the health inspection agency listed in Item 5 to perform the inspection requested in Item 8 for the facility listed in Item 10. Upon the Department's receipt of a properly completed inspection report, payment will be processed by the Department to the health inspection agency in accordance with the fee schedule established by the health inspection agency and agreed to by the Department as of the date of this inspection request.

Signature of Licensing Consultant/Worker _____ Date _____

22. Inspection fee amount \$ _____

◀ **To Be Completed by Health Inspection Agency**

23. A properly completed inspection report as requested was received on: (date) _____

Signature of Licensing Consultant/Worker _____ Date _____

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| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. | AUTHORITY: 1979 PA 218 & 1973 PA 116. COMPLETION: Required NON-COMPLETION: No license will be issued. |
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