GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

RE: ADULT FOSTER CARE APPLICATION – GROUP HOME LICENSE

Dear Applicant:

Enclosed is the application you requested.

The following is information regarding application for an adult foster care group home. 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) for the appropriate license fee, payable to the "**State of Michigan**," to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems
P.O. Box 30664
Lansing, MI 48909-8164

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: https://www.michigan.gov/documents/lara/AFC_external_coverage_list_10-1-2015_504032_7.pdf.

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

Thank you.

Adult Foster Care Inquirer & Applicant Assistance

In an effort to better serve Adult Foster Care (AFC) inquirers and applicants, the Bureau of Community and Health Systems (BCHS) offers application assistance. There is an online tutorial on our website located at: https://www.michigan.gov/lara/0,4601,7-154-89334_63294_27717_66570_66573-122898--,00.html. Field office staff also provide 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 BCHS field office **before submitting an application**. Please review the BCHS 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 BCHS field offices provide one-on-one technical assistance in individual meetings and phone conferences; you must call your assigned office for appointments: Escanaba, Flint, Grand Rapids, Kalamazoo, Lansing, Marquette, Midland, Saginaw and Traverse City.

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

PART I
ORIGINAL APPLICATION INSTRUCTIONS
ADULT FOSTER CARE GROUP HOMES

ALL APPLICANTS

This instruction sheet specifies forms and information that must be completed.

A. THE APPLICATION

(1) WHICH APPLICATION SHOULD YOU USE?

- If the applicant is an individual(s), use BCAL 569-I.
- If the applicant is any type of corporation or LLC, government agency or other organization, use BCAL 569-C.
- If the license is to be issued in the name of a Corporation or Limited Liability Company (LLC), Use BCAL 569-C.

NOTE: Prior to submitting a corporate application, you must first form your corporation/LLC through the Department of Licensing and Regulatory Affairs **AND** obtain a Federal Identification Number from the Internal Revenue Service.

Complete all areas, **SIGN AND DATE**

(2) APPLICATION FEE ONLY

Using the fee schedule included on the application, select the appropriate fee. Write a check payable to the State of Michigan. **Please do not send cash.**

NOTE: Both a completed license application and license application fee MUST be received before your application will be enrolled.

(3) LICENSING RECORD CLEARANCE REQUEST FORM (BCAL-1326A-FP).

The Licensing Record Clearance Request (**BCAL 1326A-FP**) and the Livescan Fingerprint Background Check Request (**RI-030**) forms **must be submitted/returned to the licensing unit together**.

Call the licensing unit at 1-866-685-0006 for a copy of the BCAL-1326A-FP form and the RI-030 form.

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 assess the good moral character of the individuals listed below. A Licensing Record Clearance Request will need to be completed and submitted for:

- **Applicant/Licensee -** if the license applicant is an individual, as entered on the application.

- **Licensee designee -** if the license applicant is a corporation/LLC, etc. This is the individual authorized to act on behalf of the corporation/LLC and must be named on the application. You may only designate one individual.

- **HFA Authorized Representative.**

  Background check information is required. Receiving the Clearance Request Forms and the review of the information on them allow the processing of your application.

  1979 PA 218, Sec. 12 (21) requires the applicant, if an individual, the licensee designee, owner, partner, or director of the applicant **who has regular direct access to residents or who has on-site facility operational responsibilities** 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 the facility since submitting fingerprints, a new fingerprint submission is not required.)

B. Fire Safety Plan Review (7 or more residents)

If your application is for 7 or more residents, your facility will need to be inspected by the Bureau of Construction Codes and Fire Safety.

You are required to submit building plans to the Department of Licensing and Regulatory Affairs (LARA), Bureau of Construction Codes and Fire Safety (BCCFS) for approval. You must submit form BCC-979 with your plans. This form, and the fire safety administrative rules for AFC's of 7 or more, may be obtained by visiting the LARA-BCCFS website.

C. ENVIRONMENTAL HEALTH INSPECTIONS

The local county health authority must inspect all facilities that have private well and/or private sewage disposal systems.

NOTE: UPON ASSIGNMENT OF A LICENSING CONSULTANT AND PRIOR TO COMMENCEMENT OF NEW CONSTRUCTION, YOU ARE REQUIRED TO SUBMIT YOUR FLOOR PLANS TO YOUR CONSULTANT FOR REVIEW AND FOR APPROVAL.

The Department will arrange both the fire and environmental health onsite inspections.

Upon receipt of your completed application, application fee, and the receipt and processing of all record clearance requests, your application will be forwarded to the appropriate field office and assigned to a licensing consultant. The licensing consultant will contact you regarding your application.

If you are applying as an **INDIVIDUAL**, you should have the documents listed in **PART II** of these instructions prepared.

If you are applying as a **CORPORATION/LLC**, you should have the documents listed in **PART III**, of these instructions prepared.

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

NOTICE TO ALL ADULT FOSTER CARE APPLICANTS/LICENSEES Issued: November 3, 2006

Subject: Requirements for Plan Review of AFC Facilities

Plan examination approvals, and subsequent inspections of the Bureau of Fire Services, are required for facilities that are licensed for seven or more residents. Signed and sealed architectural plans are required to be submitted for review of construction, remodeling, alterations, and change of licensee in accordance with Rule 104 of the 1994 Adult Foster Care Fire Safety Rules. Plans shall have all information as stated in Rule 104.

A complete copy of the 1994 Adult Foster Care Fire Safety Rules and the required "Application for Fire Safety Plan Examination" form can be obtained from our website at www.michigan.gov/bfs . Once in the website, click Bureau of Fire Services and then scroll down to "Public Acts & Admin. Rules" then 'Admin Rules' then 'Adult Foster Care Facilities' to get the rules. The application can be found under forms then select "Application for Fire Safety Plan Examination". This application must be filled out in its entirety in order to be considered.

1. Facility Size: 7-12 or 13-20 residents
2. Application for Fire Safety Plan Examination
3. Complete floor plan drawn accurately to scale, signed and sealed by an architect or engineer
4. Use and dimensions of each room
5. Location and size of windows
6. Size, clear width, location, direction of swing, and fire rating/construction of doors
7. Location and enclosure of exits
8. Type of construction: (per NFPA 220)
9. Interior finish: (plaster, gypsum board, paneling)
10. Location of fuel-fired devices: (furnace, water heater, etc.)
11. Heating system: (forced-air, hot water boiler, electric, etc.)
12. Type, size, and location of fire extinguishers
13. Exit sign locations
14. Any additional information to indicate compliance with the fire safety rules.

Submit your plans to:

(Via regular U.S. Mail)
Bureau of Fire Services
Plan Review Division
P.O. Box 30700
Lansing, MI 48909

(Via all other courier services)
Bureau of Fire Services
Plan Review Division
2407 N. Grand River
Lansing, MI 48906

If you have any questions regarding the submittal process, please contact the Plan Review Division at 517-241-8847.

BUREAU OF FIRE SERVICES
P.O. BOX 30700,• LANSING, MICHIGAN 48909
Phone (517) 241-8847 Fax (517) 335-4061
www.michigan.gov/bfs

PART II
APPLICATION INSTRUCTIONS
GROUP HOMES

DOCUMENTS REQUIRED FOR INDIVIDUAL APPLICANTS

"PA 218 Sec." is referring to Act No. 218 of the Public Acts of 1979, as amended. "R..." is referring to licensing rules for Adult Foster Care Small Group Homes (12 or less).

_____ **PA 218 Sec 13 (4)/R103 (f) Proof of ownership.** You will need to submit **proof of ownership** (e.g., copy of registered deed, property tax statement with owner's name on it)

_____ **PA 218 Sec 13 (4)//R103 (1)(f) Right to occupy/permission to inspect**. If you do not own the property, you will need to submit written verification of your **right to occupy** (i.e. lease or purchase agreement) and **permission to inspect from the legal owner.**

FACILITIES FOR 7 OR MORE RESIDENTS

_____ **P.A. 218 Sec, 16 (2) Zoning Approval.** You will need to obtain and submit written zoning approval, a variance or a special use permit from the local zoning authority. If local zoning approval is not obtained, a license cannot be issued.

NOTE: AN ONSITE INSPECTION WILL NOT BE CONDUCTED UNTIL THE LICENSING CONSULTANT HAS RECEIVED THE ABOVE DOCUMENTS.

_____ **PA 218 Sec 26a/R102 (1)(r)/R103 (1)(a) Program Statement.** You will need to submit a written description of the home's program according to the definition in R 102(1)(r).

Note: If your program statement indicates that you will be providing services to persons with Alzheimer's disease, your program statement must meet the requirements of PA 218 Sec 26b.

_____**R102 (1)(c)/R102 (1)(i) Admission/Discharge Policy.** You will need to submit a written admission policy according to the definition in R102 (1)(c). You will need to submit a written discharge policy, which must comply with R102 (1)(i) and all the requirements in R302 (4) and (5).

_____**R103 (1)(b)(i)/R207 (1)(a-f) Required Personnel Policies.** You will need to develop, and make available for your consultant to review, the personnel policies outlined in R207 (1) (a-f).

_____**R103 (1)(b)(ii) Job Descriptions.** You will need to develop, and make available for your consultant to review, all facility job descriptions.

_____**R103 (1)(b)(iii) Standard or Routine Procedures.** You will need to develop, and make available for your consultant's review, any standard or routine procedure.

_____**R103 (1)(b)(iv) and R206 (1) and (2) Proposed Staffing Pattern.** You will need to develop, and make available for your consultant's review, your proposed staffing pattern for the facility. The staffing pattern must identify the staffing ratio that will be maintained in the home 24 hours per day, 7 days a week.

_____**R103 (1)(b)(v) Organizational Chart.** You will need to develop, and make available for your consultant's review, a chart of your organizational structure.

_____**R103(c) Contract(s)**. You will need to make available for your consultant's review, copies of agreements or contracts.

_____**R103 (1)(d) Floor Plan.** You will need to submit a floor plan of the facility, which meets the requirements of R103 (1)(d). 400.14405 (1-9), 400.14407 (1-7), 400.14408 (1-9), 400.14409 (1-9) and all five safety rules.

NOTE: UPON ASSIGNMENT OF A LICENSING CONSULTANT AND PRIOR TO COMMENCEMENT OF NEW CONSTRUCTION, YOU ARE REQUIRED TO SUBMIT YOUR FLOOR PLANS TO YOUR CONSULTANT FOR REVIEW AND FOR APPROVAL.

_____**R103 (1)(e) Financial Documents.** You will need to make available copies of the proposed annual budget and financial statement.

_____**R103 (1)(h) Credit Report.** You will need to submit a copy of a current credit report for each person listed as an "applicant".

_____**R201 (3)(a-i) Applicant and Administrator Training.** You will need to submit verification that all applicants and the administrator are competent in all required areas.

_____**R201 (6) Applicant and Administrator Education and Experience.** Each person listed on the application as an applicant and the administrator will need to provide proof that he/she has a high school diploma or equivalent and at least one year of experience working with the population(s) identified in the home's program statement and admission policy.

_____**R201 (10) Suitability.** You are responsible for assuring that the employees, direct care staff and volunteers under the direction of the licensee are suitable. You must, therefore, have a method for determining the suitability of these individuals. Your determination must be documented for each individual.

_____**R201 (14) Food Preparation. For homes of 7 or more only.** You will need to provide proof that you have at least one individual that is qualified by training, experience and performance to be responsible for food preparation.

_____**R204 (3)(a-g) Staff Training.** It is your responsibility to assure that all staff are competent in all of the required areas prior to performing assigned tasks.

_____**R312 (4)(a) Proper Handling of Medications.** You will need to provide proof that all staff that administer medications have been trained in the proper handling and administration of medication.

_____**R205 (2) Health of Licensee and Administrator.** You will need to have the enclosed Licensing Medical Clearance form (BCAL-3704) completed by a licensed physician or his/her designee and signed and **dated within 6 months prior to the issuance of an original license,** for each license applicant and the administrator.

_____**R205 (4) and (5) TB Testing.** You will need to submit proof of TB testing results **dated within 3 years prior** to the issuance of the original license for each applicant and the administrator.

_____**R206 (5) Designated Person.** You will need to designate, in writing, a person who has the authority to carry out the licensee's or administrator's responsibilities in his/her absence.

_____**R209 (2) Emergency Repairs.** You will need to have available for review a copy of your arrangements for emergency repairs for heating, cooling, plumbing and electrical equipment.

NOTE: The items above are only some of the required documents and information needed. You consultant may ask for additional information based on your situation as part of the licensing process. It is your responsibility to review the rule and statutory requirements and demonstrate compliance to the department.

> PA 218, sec 13(19) "*Completed application" means an application complete on its face and submitted with any applicable licensing fees as well as any other information, records, approval, security, or similar item required by law or rule from a local unit of government, a federal agency, or a private entity but not from another department or agency of this state.*

Your application will not be considered complete until all items listed above, as well as any requested by your licensing consultant, have been reviewed and approved AND compliance with all licensing requirements has been determined. A recommendation for licensure cannot be made until your application is complete.

REMINDER:

Rule 103(5) requires that "an applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for license, including changes in the household and in personnel-related information, within 5 business days after the change occurs."

PART III
APPLICATION INSTRUCTIONS
ADULT FOSTER CARE GROUP HOMES

DOCUMENTS REQUIRED FOR CORPORATE/LLC APPLICANTS

"PA 218 Sec." is referring to Act No. 218 of the Public Acts of 1979, as amended. "R..." is referring to licensing rules for Adult Foster Care Small Group Homes (12 or less).

_____**PA 218 Sec 13(4)/R103 (f) Proof of ownership.** You will need to submit verification of **proof of ownership** (e.g. copy of registered deed, property tax statement with owner's name on it).

_____**PA 218 Sec 13(4)/R103 (1)(f) Right to occupy/permission to inspect.** If you do not own the property, you will need to submit written verification of your **right to occupy** (i.e. lease or purchase agreement) and **permission to inspect** from the legal owner.

_____**PA 218 Sec 16(2) Zoning Approval For facilities of 7 or more.** You will need to obtain and submit written zoning approval, a variance or a special use permit from the local zoning authority. If local zoning approval is not obtained, a license cannot be issued.

NOTE: AN ONSITE INSPECTION WILL NOT BE CONDUCTED UNTIL THE LICENSING CONSULTANT HAS RECEIVED THE ABOVE DOCUMENTS.

_____**PA 218 Sec 26a/R102 (1)(r)/R103 (1)(a) Program Statement.** You will need to submit a written description of the home's program according to the definition in R 102(1)(r).

Note: If your program statement indicates that you will be providing services to persons with Alzheimer's disease, your program statement must meet the requirements of PA 218 Sec 26b.

_____**R102 (1)(c)/R102 (1)(i) Admission/Discharge Policy.** You will need to submit a written admission policy according to the definition in R102 (1)(c). You will need to submit a written discharge policy, which must comply with R102 (1)(i) and all the requirements in R302 (4) and (5).

_____**R103 (1)(b)(i)/R207 (1)(a-f) Required Personnel Policies.** You will need to develop, and make available for your consultant to review, the personnel policies outlined in R207 (1) (a-f).

_____**R103 (1)(b)(ii) Job Descriptions.** You will need to develop, and make available for your consultant to review, all facility job descriptions.

_____**R103 (1)(b)(iii) Standard or Routine Procedures.** You will need to develop, and make available for your consultant's review, any standard or routine procedure.

_____ **R103 (1)(b)(iv) and R206 (1) and (2) Proposed Staffing Pattern.** You will need to develop, and make available for your consultant's review, your proposed staffing pattern for the facility. The staffing pattern must identify the staffing ratio that will be maintained in the home 24 hours per day, 7 days a week.

_____**R103 (1)(b)(v) Organizational Chart.** You will need to develop, and make available for your consultant's review, a chart of your organizational structure.

_____**R103(c) Contract(s)**. You will need to make available for your consultant's review, copies of agreements or contracts.

_____**R103 (1)(d) Floor Plan.** You will need to submit a floor plan of the facility that meets the requirements of R103 (1)(d). 400.14405 (1-9), 400.14407 (1-7), 400.14408 (1-9), 400.14409 (1-9) and all five safety rules for facilities to be licensed for 6 or l4ss.

NOTE: UPON ASSIGNMENT OF A LICENSING CONSULTANT AND PRIOR TO COMMENCEMENT OF NEW CONSTRUCTION, YOU ARE REQUIRED TO SUBMIT YOUR FLOOR PLANS TO YOUR CONSULTANT FOR REVIEW AND FOR APPROVAL.

_____**R103 (1)(e) Financial Documents.** You will need to submit copies of the following documents:

1. **A Newly Formed Corporation/LLC will need to submit:**
   - An annual budget projecting expenses and income.
   - A letter of intent to contract for services from a placing agency, if applicable.

2. **An Existing Corporation/LLC (1 year or more) will need to submit:**
   - An annual budget showing expected expenses and income.
   - A current financial statement for the corporation/LLC.
   - A letter of intent to contract for services from a placing agency, if applicable.

3. **A component of Government (i.e. community mental health, county infirmary, etc.) will need to provide a:**
   - Statement of financial accountability from the primary unit of government for the component unit of government.
   - Current financial statement for the component unit of government.
   - Operating budget showing expected expenses and income.

_____**R103 (1)(g) Other Corporate/LLC Documents**

1. **Corporations are required to provide:**
   - A current listing of the corporation's board of directors.
   - The current articles of incorporation.
   - The current by-laws.
   - A letter of authorization from the board of directors that designates the individual who is authorized to act on behalf of the corporation in licensing matters (also referred to as the *licensee designee* on the application).

2. **Limited Liability Companies (LLC) will need to provide:**
   - A current listing of the members and managers, including names, addresses and telephone numbers.
   - Current articles of organization.
   - A letter of authorization from the manager(s) that designates ONE individual who is authorized to act on behalf of the LLC in licensing matters (also referred to as the licensee designee on the application).

_____**R201 (3)(a-i) Licensee Designee and Administrator Training.** You will need to submit documentation that the licensee designee and the administrator are competent in all required areas.

_____**R201 (6) Licensee Designee and Administrator Education and Experience.** The license designee and the administrator will need to provide proof that each has a high school diploma or equivalent and at least one year of experience working with the population(s) identified in the home's program statement and admission policy.

_____**R201 (10) Suitability.** You are responsible for assuring that the employees, direct care staff and volunteers under the direction of the licensee are suitable. You must, therefore, have a method for determining the suitability of these individuals. Your determination must be documented for each individual.

_____**R201 (14) Food Preparation. For homes of 7 or more only.** You will need to provide proof that you have at least one individual who is qualified by training, experience and performance to be responsible for food preparation.

_____**R204 (3)(a-g) Staff Training.** It is your responsibility to assure that all staff are competent in all of the required areas prior to performing assigned tasks.

_____**R312 (4)(a) Proper Handling of Medications.** You will need to provide proof that all staff that administer medications have been trained in the proper handling and administration of medication.

_____**R205 (2) Health of Licensee and Administrator.** You will need to have the enclosed Licensing Medical Clearance form (BCAL-3704-AFC) completed by a licensed physician or his/her designee and signed and **dated within 6 months prior to the issuance of an original license**. This form is to be used for the licensee designee and the administrator. You will need to submit the enclosed form to your consultant.

_____**R205 (4) and (5) TB Testing.** You will need to submit proof of TB testing results **dated within 3 years prior** to the issuance of the original license for the licensee designee and the administrator.

_____**R206 (5) Designated Person.** You will need to designate in writing the person who has the authority to carry out the licensee designee's or administrator's responsibilities in their absence.

_____**R209 (2) Emergency Repairs.** You will need to have available for review a copy of your arrangements for emergency repairs for heating, cooling, plumbing and electrical equipment.

NOTE: The items above are only some of the required documents and information required. You consultant may ask for additional information based on your situation as part of the licensure process. It is your responsibility to review the rule and statutory requirements and demonstrate compliance to the department.

> PA 218, sec 13(19) "*Completed application" means an application complete on its face and submitted with any applicable licensing fees as well as any other information, records, approval, security, or similar item required by law or rule from a local unit of government, a federal agency, or a private entity but not from another department or agency of this state.*

Your application will not be complete until all items listed above, as well as any requested by your licensing consultant, have been reviewed and approved AND compliance with all licensing requirements has been determined. A recommendation for licensure cannot be made until your application is complete.

REMINDER:

Rule 103(5) requires that "an applicant or licensee shall give written notice to the department of any changes in information that was previously submitted in or with an application for license, including changes in the household and in personnel-related information, within 5 business days."

ADULT FOSTER CARE LICENSE INDIVIDUAL APPLICATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

FOR CASHIER USE ONLY – Cashier Code: 100101
License Number:
Paid Amount:
Cashier:

SECTION I – FACILITY INFORMATION

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

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 46-47, 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 facility from Bureau of Community and Health Systems 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?	☐ Yes	☐ No	f.	Had a default judgment?	☐ Yes	☐ No
b.	Had a seizure of assets?	☐ Yes	☐ No	g.	Had a repossession or foreclosure?	☐ Yes	☐ No
c.	Had a lien enforced against it?	☐ Yes	☐ No	h.	Had a notice of eviction due to payment problems?	☐ Yes	☐ No
d.	Had financial assets frozen?	☐ Yes	☐ No	i.	Had a garnishment or attachment of wages or income?	☐ Yes	☐ No
e.	Had a contract to receive public or private monies not renewed or terminated prior to its expiration?					☐ Yes	☐ 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 Licensing and Regulatory Affairs 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 Licensing and Regulatory Affairs 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:

	ORIGINAL or RENEWAL		**ORIGINAL or RENEWAL**
Family Home 3 – 6	$ 100.00	Large Group Home 13 – 20	$500.00
Small Group Home 3 – 6	$150.00	Congregate Facility 21+	$500.00 (Renewal Only)
Small Group Home 7 – 12	$200.00		

LARA is an equal opportunity employer/program.	AUTHORITY: 1979 PA 218 COMPLETION: NON-COMPLETION: Mandatory License issuance will be denied

ADULT FOSTER CARE LICENSE
LIMITED LIABILITY COMPANY, GOVERNMENTAL ORGANIZATION and CORPORATE APPLICATION

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

FOR CASHIER USE ONLY – Cashier Code: 100101
License Number:
Paid Amount:
Cashier:

SECTION I – FACILITY INFORMATION

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

SECTION II – APPLICANT/LICENSEE INFORMATION

E-mail address

22. Corporate/Limited Liability company/Governmental Organization Name	23. Telephone Number ( )	24. Fax Number ( )
25. Street Address	26. City State Zip Code	
27. Mailing Address, if different (i.e. P.O. Box)	City State Zip Code	

28. Date Incorporated/Organized	29. Federal ID Number	30. ☐ For Profit ☐ Non Profit	31. ☐ Government ☐ Non Government

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

32. Agency Name and Address	33. Name of Contact Person	34. Telephone Number
		( )
		( )
		( )
		( )

SECTION IV – LICENSEE DESIGNEE AND ADMINISTRATOR (Person responsible for the daily operation of the facility)

(Licensing Record Clearance form required to be completed by Licensee Designee or Administrator.)

35. Print Name of Licensee Designee	36. Date of Birth	37. Social Security Number	38. Print Name of the Administrator	39. Date of Birth	40. Social Security Number

41. Describe any conviction of corporate officers, company members, business owners, directors, licensee designee, administrator and non-employee adult members of the household. Do not include minor traffic violations.

42. Does the Corporation/Limited Liability Company/Governmental Organization now, or has it ever, operated an adult foster care facility, children's foster care facility, children's day care facility, child caring institution, adult or child camp, or child placing agency?
If "yes" please see Item 44. ☐ YES ☐ NO

43. Has the Corporation/Limited Liability Company/Governmental Organization ever been denied a license to operate an adult foster care facility, children's foster care facility, child or adult camp, child day care facility, child caring institution or child placing agency?
If "yes" please see Item 44. ☐ YES ☐ NO

44. If your response is YES to either item 42 or 43, complete the following information. Include all current and previous licensed programs and denied licenses. Attach additional sheets, if necessary.

Name of Licensing/Certifying Agency	Type of Care	License Number	Application Date	Open	Closed

45. Provide the following information for all persons who live in the facility, including relatives, roomers and boarders, and live-in staff. DO NOT include adult foster care residents. Attach additional sheets, if necessary.

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

46. Directions for reaching facility.

SECTION V – OWNERSHIP INFORMATION

47. Identify all ownership interest *in the business*. Attach additional sheets, if necessary.

Name	Street Address (city, state and zip)

48. Ownership of Facility to be licensed
☐ Own ☐ Rent/Lease ☐ Buying

49. Identify all ownership interest *in the property*. Attach additional sheets, if necessary.

Name	Street Address (city, state and zip)

SECTION VI – FINANCIAL INFORMATION

All questions must be answered by a member of the licensee company or board
Attach an explanation for each "YES" response:

50. HAS TO CORPORATION/LIMITED LIABILITY COMPANY/GOVERNMENTAL ORGANIZATION EVER:

a. Filed for bankruptcy?	☐ YES	☐ NO	f. Had a default judgment against it?	☐ YES	☐ NO
b. Had a seizure of assets?	☐ YES	☐ NO	g. Had a repossession or foreclosure?	☐ YES	☐ NO
c. Had a lien enforced against it?	☐ YES	☐ NO	h. Had a notice of eviction due to payment problems?	☐ YES	☐ NO
d. Had its financial assets frozen?	☐ YES	☐ NO	i. Had a garnishment/attachment of wages/income?	☐ YES	☐ NO
e. Had a contract to receive public monies not renewed or terminated prior to its expiration?				☐ YES	☐ NO

51. HAS ANY OFFICER OF THIS CORPORATION/LIMITED CORPORATION/GOVERNMENTAL ORGANIZATION EVER BEEN AN OFFICER/PARTNER OF ANOTHER CORPORATION/LIMITED LIABILITY CORPORATION/GOVERNMENTAL ORGANIZATION OR PARTNERSHIP THAT:

a. Filed bankruptcy?	☐ YES	☐ NO
b. Had a contract to receive public monies not renewed or terminated prior to its expiration?	☐ YES	☐ NO
c. Has been subject to a government seizure of assets?	☐ YES	☐ NO

SECTION VII – CERTIFICATION AND SIGNATURES

I have a read 1979 PA 218, as amended, 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 Michigan Department of Licensing and Regulatory Affairs to make a necessary and reasonable investigation of my activities and proposed standards of care and to make an on-site inspection of the facility.

I am aware of the legal provisions of Section 13 and Section 31 of 1979 PA 218, as amended, 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, I shall report such information to the Department.

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

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

52. Signature of a member of the licensee company or board	53. Date

Note: May not be signed by the licensee designee unless also a member of the licensee company or board.

54. **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:

	ORIGINAL or RENEWAL		**ORIGINAL or RENEWAL**
Small Group Home 3-6	**$150.00**	**Large Group Home 13-20**	**$500.00**
Small Group Home 7-12	**$200.00**	**Congregate Facility 21 +**	**$500.00 (Renewal Only)**

LARA is an equal opportunity employer/program.	AUTHORITY: 1979 PA 218 COMPLETION: Mandatory NON-COMPLETION: License issuance will be denied

If you have multiple individuals in the home that will require additional forms, please print additional copies of this form before filling it out.

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

Michigan Department of Licensing and Regulatory Affairs
Bureau of Community and Health Systems

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)

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 Licensing and Regulatory Affairs, Bureau of Community and Health Systems, 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)

- **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.?	Date Tested	Test Type	Results
☐ No ☐ Yes If Yes		☐ Skin Test ☐ X-Ray	☐ Positive (Explain in Comments) ☐ Negative

How would you describe the patient's general physical/mental condition and health? (Use Comments section for explanations)

- ☐ No physical/mental condition or health problem exists that would limit the ability to work with or around dependent adults.
- ☐ 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.
- ☐ 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? ☐ Yes ☐ 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.

LARA is an equal opportunity employer/program.