GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

RE: ADULT FOSTER CARE FAMILY HOME APPLICATION

Dear Applicant:

The following is information regarding application for an adult foster care family home for capacity 3 to 6. 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 $100.00 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 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 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 BCHS field office indicated for application assistance.

The following BCHS field offices provide individual one on one information meetings; you must call the assigned office for an appointment: Flint, Grand Rapids, Jackson, 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.

ORIGINAL APPLICATION INSTRUCTIONS
ADULT FOSTER CARE FAMILY HOMES
3-6 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 $100.00 payable to the "State of Michigan".

PLEASE DO NOT SEND CASH

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

The Licensing Record Clearance Request (**BCAL 1326A-FP**) and the Live Scan 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.)

Additional Documentation You Will 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.**

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.**

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