



Family Systems Application

Division of Licensing

Application for: Family child care Adult foster care Family adult day services
This is a (check one): New application Renewal

Note: For child foster care, use the commissioner's designated format (One Study)

This information is available in alternative formats to individuals with disabilities by contacting us at (651) 296-3971. TTY users can call through Minnesota Relay at (800) 627-3529. For the Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.

Attention. If you want free help translating this information, call (651) 431-3850.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم (651) 431-3850 .

កំណត់សំគាល់ ដើម្បីទទួលបានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ (651) 431-3850 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite (651) 431-3850 .

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, hu (651) 431-3850 .

ໂປຼຕຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ. ຈົ່ງ ໂທຣ໌ຫາ (651) 431-3850 .

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsi bilbiltu (651) 431-3850 .

Внимание: если вам нужна бесплатная помощь в переводе этой информации, позвоните (651) 431-3850 .

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkanii oo lacag la'aan ah, wac (651) 431-3850 .

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al (651) 431-3850 .

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi (651) 431-3850 .

LBI-0001 (1-08)

Facility - Identifying information

APPLICANT NAME (<i>Last, first, MI</i>)	OTHER NAMES USED	BIRTH DATE
CO-APPLICANT NAME (<i>Last, first, MI</i>)	OTHER NAMES USED	BIRTH DATE
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE (<i>9-digit</i>)

Provider - Identifying information

ORGANIZATIONAL STRUCTURE <i>(Check one)</i>		
<input type="checkbox"/> Government unit	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Owner	<input type="checkbox"/> Managerial official	<input type="checkbox"/> Controlling individual
APPLICANT NAME		BIRTH DATE
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

AUTHORIZED REPRESENTATIVE <i>(Last, first, MI)</i>		BIRTH DATE
STREET ADDRESS (AUTHORIZED REPRESENTATIVE)		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

Special family child care home - Identifying information

ORGANIZATIONAL STRUCTURE <i>(Check one)</i>		
<input type="checkbox"/> Employer	<input type="checkbox"/> Church	<input type="checkbox"/> Nonprofit
<input type="checkbox"/> Community collaborative		
NAME (EMPLOYER, CHURCH AND/OR COMMUNITY COLLABORATIVE)	CONTACT PERSON <i>(Last, first, MI)</i>	
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE <i>(9-digit)</i>

Dwelling information *(Check all that apply)*

- Owned Rented Single family house Mobile home
 Multi-unit Attached garage Basement Wood burning stove or fireplace
 Second floor Above second floor

Previous licensure

Are you currently or have you been licensed? Yes No

TYPE OF LICENSE <i>(Check all that apply)</i>		
<input type="checkbox"/> Child care	<input type="checkbox"/> Child foster care	<input type="checkbox"/> Adult foster care
<input type="checkbox"/> Family adult day services		
LICENSE NUMBER	COUNTY/AGENCY/STATE	DATES

All children and adults living/working in the dwelling

1. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
2. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
3. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
4. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
5. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
6. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
7. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE
8. NAME (<i>Last, first, MI</i>)	RELATIONSHIP	GENDER	BIRTH DATE

References- Required at initial licensure only (Nonrelated individuals) Not required for FADS

1. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

2. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

3. NAME (<i>Last, first, MI</i>)		
STREET ADDRESS		TELEPHONE NUMBER
CITY	STATE	ZIP CODE

For family child care

Class of license <i>(Check one)</i>	Total children including own					
	Adult	Total capacity	School age	Total under school age	Toddler/infants	Max number Toddler/infants
<input type="checkbox"/> A-Family	1	10	4	6	3	3 or 2
<input type="checkbox"/> B1-Family (Spec Inft & T)	1	5	2	3	3	3 or 2
<input type="checkbox"/> B2-Family (Spec Inft & T)	1	6	2	4	4	4 or 2
<input type="checkbox"/> C1-Group Family	1	10	2	8	3	3 or 2
<input type="checkbox"/> C2-Group Family	1	12	2	10	2	2 or 1
<input type="checkbox"/> C3-Group Family	2	14	4	10	4	4 or 3
<input type="checkbox"/> D-Group (Spec Inft & T)	2	9	2	7	7	7 or 4

Hours of operation

Open from the month of: _____ through the month of: _____

Hours for the day of:

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

Special family child care information

Church care
 Employer care
 Community collaborative
 Not-for-profit

For adult foster care

TYPE OF CLIENT PREFERRED *(check all that apply):*

Developmentally disabled
 Physically handicapped
 Chemically dependent
 Mentally ill
 Elderly

GENDER

Male
 Female
 Either

LICENSED CAPACITY

For family adult day services

LICENSED CAPACITY _____

Hours of operation

Hours for the day of:

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

The information that I have provided on this application is true and accurate. If the commissioner of Human Services grants me a license, I agree to comply with the requirements contained in Minnesota Rules and Statutes at all times during the term of the license. I agree that the commissioner's representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect my home and its grounds at any time during the hours that I provide care. Further, I agree that the documentation and inspection required by the rules is necessary for the commissioner to determine whether I am complying with Minnesota Rules and Laws.

Finally, I agree that any documentation that I provide or representations that I make to the commissioner's representative during the time that I am licensed will be true and accurate and that any misrepresentations or other violations of Minnesota Rules and Laws may result in immediate suspension or revocation of the license.

SIGNATURE OF APPLICANT _____	DATE _____
SIGNATURE OF CO-APPLICANT _____	DATE _____

Agency use only

Date returned to agency _____/_____/_____	BGS sent _____/_____/_____
Fire inspection requested _____/_____/_____	Attended orientation _____/_____/_____

Attention. If you want free help translating this information, call 1-888-234-1321 or 651-431-3366.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم 1-888-234-1321 أو 651-431-3366.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ 1-888-234-1321 ឬ 651-431-3366។

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