



Family Systems Application

Division of Licensing

Application for: Family child care Adult foster care Family adult day services
 Adult foster care alternate overnight supervision technology

This is a (check one): New application Renewal Application to change existing AFC program

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 បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទទៅ (651) 431-3850 ។

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

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

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງ ໂທລັອກ (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 macluumaadkani 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.

L134-0001 (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*)

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Owned | <input type="checkbox"/> Rented | <input type="checkbox"/> Single family house | <input type="checkbox"/> Mobile home |
| <input type="checkbox"/> Multi-unit | <input type="checkbox"/> Attached garage | <input type="checkbox"/> Basement | <input type="checkbox"/> Wood burning stove or fireplace |
| <input type="checkbox"/> Second floor | <input type="checkbox"/> 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	Max under school age	Max Toddler/infants	Max number infants
<input type="checkbox"/> A-Family	1	10	6	3	2
<input type="checkbox"/> B1-Family (Spec Inft & T)	1	5	3	3	3
<input type="checkbox"/> B2-Family (Spec Inft & T)	1	6	4	4	2
<input type="checkbox"/> C1-Group Family	1	10	8	3	2
<input type="checkbox"/> C2-Group Family	1	12	10	2	1
<input type="checkbox"/> C3-Group Family	2	14	10	4	3
<input type="checkbox"/> D-Group (Spec Inft & T)	2	9	7	7	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	_____		

For adult foster care

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

Developmentally disabled
 Physically handicapped
 Chemically dependent
 Mentally ill
 Elderly

GENDER	LICENSED CAPACITY
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either	

Alternate overnight supervision technology applicants complete this section.

RESPONSE ALTERNATIVE

1 *(One)* 2 *(Two)*

LEAD COUNTY CONTRACT MANAGER <i>(name/county)</i>	PHONE
HOST COUNTY <i>(service site)</i> CONTRACT MANAGER <i>(if different than above) (name/county)</i>	PHONE

Please submit documentation of items required on the Adult Foster Care Alternate Overnight Supervision Technology Checklist, DHS-5909.

For family adult day services

LICENSED CAPACITY

Hours of operation

Hours for the day of:

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

Applicants for a residential program (adult foster care) license issued by the Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to inquire about applicable local ordinance requirements.

The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Please document the following regarding your contact with the local municipality.

NAME OF MUNICIPALITY	DATE OF CONTACT
NAME OF OFFICIAL	PHONE NUMBER

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

INITIAL LICENSING EVALUATION - APPLICANT

Provider's Name: _____

Address: _____

1. List the rooms in your home that will be used by day-care children and the usable square footage for each.

<u>Rooms</u>	<u>Square Footage</u>	<u>Comments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Usable outdoor play space is _____ square feet.
3. Is your yard fenced? (Not always required.) _____
4. Do all stairways with three or more steps have handrails? _____
5. Is the area between the handrails and the steps properly enclosed/protected?

6. Do you have secure gates or doors on your stairways? _____
7. Can your bathroom door be opened from the outside if locked? _____
8. Are all electrical outlets accessible to children under first grade covered or protected when not in use? _____
9. Are there any guns or firearms in the residence or on the property?
_____ If yes, where are they and the ammunition stored?

10. What size/classification is your fire extinguisher (minimum 2A10BC)?
_____ Is it in working order? _____ Do you know
how to use it? _____
11. Do you have smoke detectors installed on all levels in your home? _____
Where are they located? _____
Date tested _____ Do they work? _____
12. Are emergency phone numbers posted by the phone? _____ Phone numbers
of the local fire department, police department, emergency transportation,
and Poison Control are required.
13. Do you have a working flashlight in your home? _____

14. Do you have a batter-operated radio or TV? _____
15. What pets do you have? _____
 Dates of last rabies shot(s) _____
 Where are pet cages/litter boxes located? _____
 Are they cleaned away from food preparation, storage, or serving areas?

16. Please list location of the following items, indicating if area is locked:
- Medicines: _____
- Cleaning Supplies: _____
- Liquor: _____
- Knives: _____
- Scissors: _____
- Sewing Equipment: _____
- Matches and Lighters: _____
- Plastic Bags and Wrap: _____
- Tools: _____
- Poisonous Plants: _____
17. Do you have the following items in your first aid supplies?
- | | |
|--------------------------|----------------------------|
| ___ Bandages | ___ Sterile compresses |
| ___ Tape | ___ Scissors |
| ___ Ice bag or cold pack | ___ Thermometers |
| ___ Soap | ___ Syrup of Ipecac |
| ___ First aid manual | ___ Expiration Date: _____ |
18. Will you ever use a vehicle to transport day-care children? _____
 If so, is the vehicle licensed according to state law? _____ Does
 the driver of the vehicle have a current driver's license? _____
19. Substitute care giver(s) in the event of an emergency is/are _____

 Signature

 Date

Blue Earth County Home Use Agreement Form

Applicant: _____

* Year Home Built: _____

Address: _____

Please check one item in each group:

Garage Separation:

- I have an attached garage. It is separated from the residence by a 5/8-inch thick gypsum wallboard or equivalent. The door is self-closing solid wood or has a fire protection rating 20 minutes or greater.
- I have an attached garage. I do not know if the separation wall and door meet the minimum standards.
- I do not have an attached garage.

Basement/Lower Levels:

- I plan to use my basement/lower level for day-care purposes, and it will be inspected and approved by a State Fire Marshal.
- I do not plan to use my basement/lower level for day-care purposes and will not use it in the future without prior approval from the agency.
- I have no basement/lower level.

Wood-Burning Stoves/Solid Fuel-Burning Appliances:

- I have a wood/solid fuel-burning appliance in my home, and I plan to use it during day-care hours. It will be inspected and approved by a State Fire Marshal.
- I have a wood/solid fuel-burning appliance in my home, but I do not plan to use it during day-care hours without prior approval from the agency.
- I have no wood/solid fuel-burning appliance in my home.

Space Heaters (electric, gas, other):

- I have a space heater in my home, and I plan to use it during day-care hours. It will be inspected and approved by a State Fire Marshal.
- I have a space heater in my home, but I do not plan to use it during day-care hours without prior approval from the agency.
- I have no space heater.

Full Second Story (not split level):

- I have a full second story in my home, and I plan to use it for day care.
- I have a full second story in my home, but I do not plan to use it for day care and will not do so in the future without prior approval from the agency.
- I have no full second story.

Applicant Signature

Date

** A Certificate of Occupancy will be accepted in lieu of fire marshal inspection for homes built after 1990.*

Floor and Escape Plan

Use this grid to draw a floor plan. Show the whole house with two exits from each room. In buildings with three or more dwelling units, enclosed exit stairs must be indicated.

Sample floor plan – A blueprint to save your life

Symbols to be used:

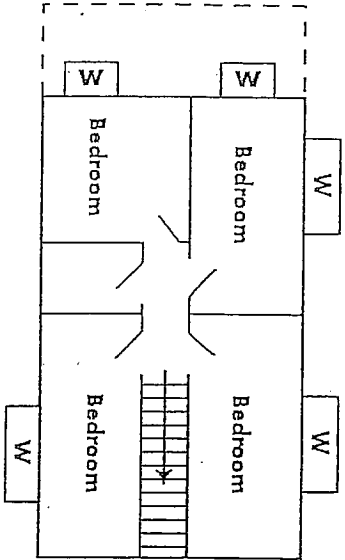
Normal exit route: Black arrow →

Emergency exit route: Red arrow →

Doors: 

Porches: 

Windows: 

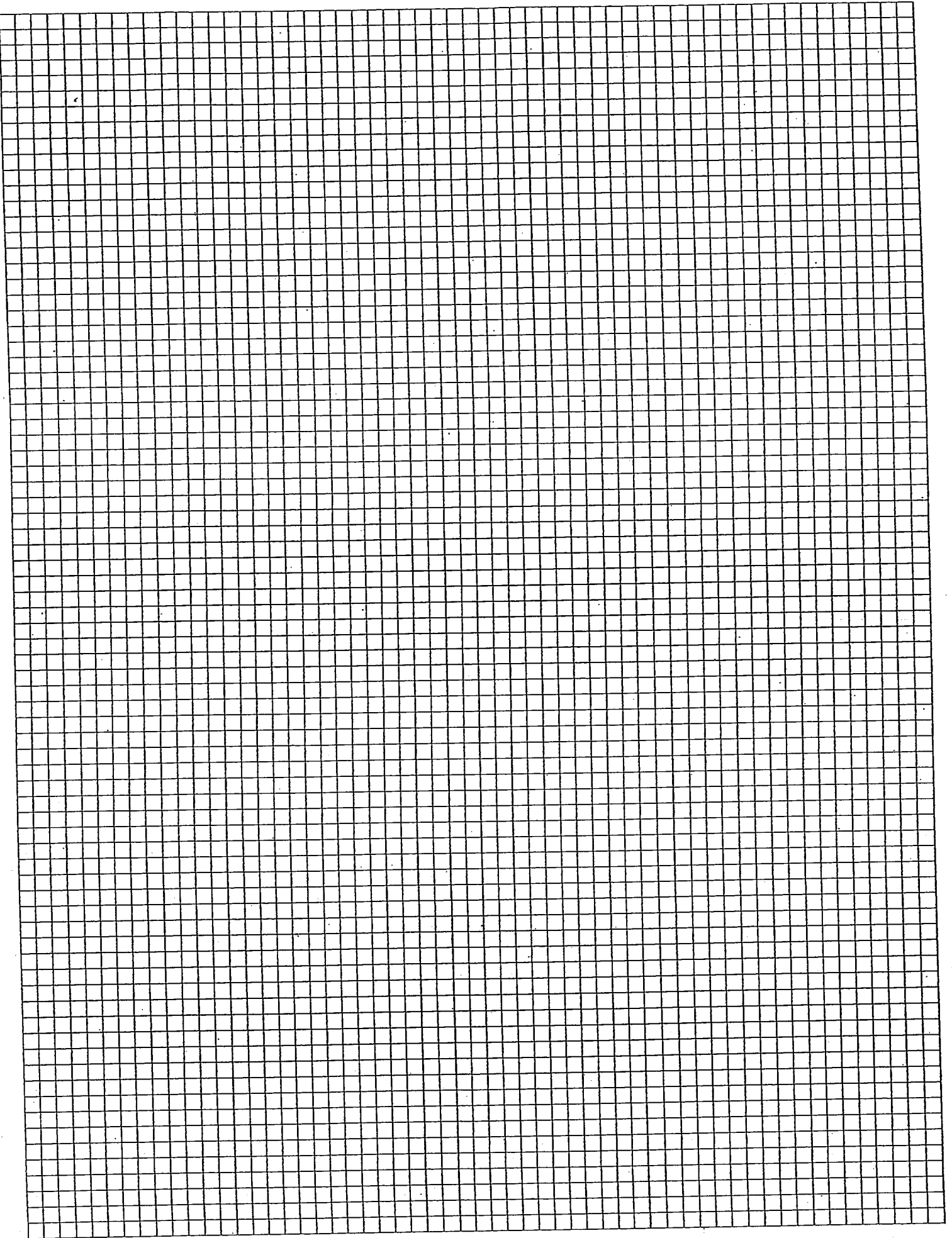


For additional space, use reverse side

Fire and police emergencies
Designate a place to meet outdoors for roll call: _____
Designate a place to meet in case of storm or tornado: _____
Fire extinguisher location: _____
Designate a temporary shelter if evacuation is necessary: _____
Specifically address the needs of children whose behavior increases the risk of having a fire: _____
Smoke detector locations: _____
Basement or lower level _____
Main floor or upper level _____
Second floor _____

Each square = 1 foot

Each square = 1 foot





Home Safety Checklist

- Adult Foster Care Child Foster Care Family Child Care

ADULT FOSTER CARE (AFC) - A Home Safety Checklist, approved by the commissioner, must be completed by the operator and the commissioner before licensure each year a fire marshal inspection is not made. Reference MN Rules, part 9555.6125, subp. 2.

CHILD FOSTER CARE (CFC) - Prior to licensure, the foster home must be inspected by a licensing agency employee using the home safety checklist from the commissioner of Human Services. Reference MN Rules, part 2960.3050, subp. 1

FAMILY CHILD CARE (FCC) - The Home Safety Checklist may be used as part of the licensing study. Reference MN Rules, parts 9502.0425-9502.0445.

Emergency Procedures

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. The emergency phone numbers are posted near the phone. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. Emergency procedures are planned, written, and posted. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. A battery powered flashlight and radio/TV is available and operable. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. First-aid supplies are readily available. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. An operable telephone is located within the residence. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Exit doors and windows are not obstructed and are easily opened from the inside. |

Physical Environment

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. The wiring appears safe; no known hazards exist. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. Extension cords are appropriately used and are not used in place of permanent wiring. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. A fire extinguisher is maintained in the kitchen cooking area or area approved by the fire marshal.
Fire extinguisher rating: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. All smoke detectors are properly installed, appropriately located, and maintained in proper operating condition. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. All interior doors can be unlocked from the outside and the key is easily accessible in the case of an emergency. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. If there is an attached garage, a proper fire separation is maintained between the house and garage. (FCC) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. The water temperature is set to prevent scalding, as appropriate; in day care homes the temperature does not exceed 120° F. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Fireplaces, wood burning stoves, and other hot surfaces are protected by guards to prevent burns. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. Furnaces are checked regularly and maintained in good working condition. |

Home Safety & Health

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 1. Knives, tools, matches, and other potentially hazardous materials are inaccessible to children, unless used with appropriate supervision. (FDC, CFC) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 2. Combustible items are properly stored at least 36" from any heating sources. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 3. Food is handled and properly stored to prevent contamination, spoilage, or a threat to health. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 4. Residence is clean and free from accumulations of dirt, rubbish, peeling paint, rodents and insects. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. Chemicals, detergents, medicines, and other toxic substances are stored separately from food products. When appropriate, these substances are inaccessible to clients. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Any Schedule II controlled substances are stored in a locked area. (AFC) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. There is a safe water supply in the residence; water from privately-owned wells is tested annually by a certified laboratory. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Individual clean towels, wash cloths, and bedding are provided for each client. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | 9. Weapons and ammunition are stored separately in locked areas. |

Remarks (Please explain all "NO" answers): _____

Obvious safety hazards or concerns?: _____

Provider Signature:	Date
Licensing Worker:	Date