APPLICATION FOR LICENSE TO OPERATE AN ADULT FOSTER CARE HOME

TO: South Dakota Department of Health
Office of Health Care Facilities Licensure & Certification
615 East 4th Street
Pierre, SD 57501-1700 Telephone No. 605-773-3356 Fax No. 605-773-6667

The undersigned hereby makes application for a license to operate an adult foster care home as required by SDCL 34-12

I. NAME AND LOCATION OF FACILITY

Applicant:_____ Date of Birth _____
Last Name First Name Middle M-D-Y
Spouse:_____ Date of Birth _____
Last Name First Name Middle M-D-Y
Address_____
(Street and Number) (City)
County_____ Zip Code (9 digit)_____ Telephone No._____ Fax No._____
Mailing Address (if different from above)_____
E-Mail Address _____

II. CAPACITY AND CLASSIFICATION OF FACILITY

A. Ownership of Building: _____
B. Number of Beds applied for: _____
C. Total number of adult foster care residents _____
D. Number of adult foster care residents that are a Family Member(s) _____
E. Placement of residents (check): ( ) Department of Human Services; ( ) Department of Social Services; ( ) Veterans Administration; ( ) Other (specify) _____
F. Water Source: [ ] Public Water System [ ] Private Water Source If private water system, are you checking for bacteria at least monthly [ ] Yes [ ] No
G. Fire drills held (dates) (during period July – June, at least four drills per year): _____ , _____ , _____ , _____ , _____ , _____.
H. Have you ever applied or registered to provide adult foster care for adults within the State of South Dakota? [ ] Yes [ ] No
If yes, when and where was this request made? _____
I. Have you, or any member of your household, ever been investigated in connection with a charge of abusing or neglecting another person? [ ] Yes [ ] No
J. Have you, or any member of your family, ever experienced problems (i.e., legal, financial, personal) resulting from the misuse of alcohol or drugs? [ ] Yes [ ] No
K. Have there been any changes in your living or family situation that could in any way affect your license (i.e. moving to another location/home, change in family size, change in marital status, serious illness, etc.)? [ ] Yes [ ] No

If yes, please state any changes.

_____
_____
_____
_____
_____

L. List alternative care givers utilized:

_____ Date of Birth:_____
Name (month/day/year)

_____ Date of Birth:_____
Name (month/day/year)

Attach additional pages, if needed.

III. APPLICANT:

I herein make application to provide Adult Foster Care with the Department of Health, under the laws of South Dakota and rules and regulations governing Adult Foster Care. I swear that the information given in support of this application is true, and I agree to cooperate with representatives of the Departments of Health, Social Services and Human Services in supplying information to ensure that adequate care, protection and safety for any individual will be maintained while under my care. Further, my signature on this application authorizes representatives with proper identification of the Department of Health to conduct regulatory investigations of my home(s).

Signature of Applicant(s):

_____ Date_____
Applicant

_____ Date_____
Spouse

Subscribed and sworn to before me this _____ day of _____, 20_____. (Seal)

Notary Public	My commission expires:

APPLICATIONS MUST BE COMPLETE, SIGNED AND NOTARIZED TO BE PROCESSED

The department will issue or renew a license only after ascertainment that the facts set forth in the application are true and complete, and satisfactory evidence of the applicant's ability to comply with the provisions of SDCL Chapter 34-12 and the rules promulgated thereunder.