# APPLICATION FOR LICENSE TO OPERATE A COMMUNITY LIVING HOME

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 a community living home as required by SDCL 34-12.

## I. NAME AND LOCATION OF FACILITY

Facility Name_____

Applicant_____

Spouse_____

Facility Address_____

City_____ County_____ Zip Code (9 digit)_____

Telephone No._____

Mailing address (if different than above)_____

E-Mail Address (required)_____

## II. CAPACITY AND CLASSIFICATION OF FACILITY

A. Ownership of Building: _____

B. Number of Beds applied for: _____

C. Total number of community living home (CLH) residents: _____

D. Placement of residents (check): ( ) Department of Human Services; ( ) Department of Social Services;

( ) Veterans Administration: ( ) Other (specify) _____

E. Water Source: 44:82:02:05 [ ] Public Water System [ ] Private Water Source

If private water system, annual bacteria test? [ ] Yes [ ] No _____(date)

F. Annual Fire drill: 44:82:03:02 _____(date)

G. Have you ever applied or registered to provide care for adults within the State of South Dakota?

[ ] No [ ] Yes If yes, when and where was this request made?

_____

H. Have you, any member of your household, or caregiver ever been investigated in connection with a conviction of abusing or neglecting another person? [ ] Yes [ ] No

I. 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, serious illness, etc.)?

[ ] No [ ] Yes If yes, please state any changes.

_____

_____

_____

J. List alternative care givers utilized (any individual shall be at least 18 years of age.)

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## III. APPLICANT:

I herein make application to the Department of Health, under the laws of South Dakota and rules and regulations governing Community Living Homes. 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.

My signature on this application authorizes representatives with proper identification of the Department of Health to conduct regulatory investigations of my home. Further, my signature indicates I have read ARSD 44:82 Community Living Home regulations.

Signature of Applicant(s):
Applicant_____ Date_____

Spouse_____ Date_____

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.

## IV. LICENSE FEE:

Submit the license fee in the amount of $150.00 attached to this application. Make check, money order, or postal note payable to the South Dakota Department of Health.

Note: Please submit original and retain one copy for your files.

**FOR HEALTH DEPARTMENT USE ONLY**
Fee received $_____ Receipt No._____ License No._____
The department will issue or renew a license only after payment of the proper fee, 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 ARSD 44:82.