WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR CHILDREN AND FAMILIES
DIVISION OF CHILDREN AND ADULT SERVICES
350 CAPITOL STREET, ROOM 691
CHARLESTON, WEST VIRGINIA 25301-3704

Application for Initial, Renewal or Amended License or Certificate of Approval to Operate a Residential Child Care and Treatment Facility or Child Placing Agency

1. Specific Name and Address of Facility or Program for which this application is being submitted (Please be very detailed; some organizations operate multiple facilities and programs).

Specific Name

Address:

City State Zip Code

Telephone Number Fax Number

E-Mail FEIN#

Agency Web Site

Director of Facility/Program

2. Type of Application

☐ INITIAL ☐ RENEWAL ☐ AMENDED

(Note: if you are requesting an amendment of an existing license please submit a letter describing changes you are proposing along with the first and last pages of this application. This should include all changes in physical structure, capacity, and program changes)

3, Type of Care (mark all that apply)

A. ☐ **Residential Child Care and Treatment Facility Psychiatric**

- ☐ **Residential Treatment Facility Residential Crisis**
- ☐ **Support/Emergency Shelter Care Residential**
- ☐ **Maternity and Parenting Facility**
- ☐ **Group Residential Facility**

☐ **Level I**	# of beds	
☐ **Level II**	# of beds	
☐ **Level III**	# of beds	

- ☐ **Outdoor Therapeutic Education Facility**
- ☐ **Intermediate Care Facility**
- ☐ **Therapeutic Residential School**

B. ☐ **Child Placing Agency**

- ☐ Adoption Foster
- ☐ Care Community Re-
- ☐ entry Transitional
- ☐ Living

4. Target Population

A. **Capacity**

B. **Age range**

C. **Gender**

D. Geographical Area

E. Population Description (**Describe what types of children will be served)**

5 Name and Administrative Address of Organization

Telephone Number

Fax Number

E-Mail

FEIN#

6. Ownership

A. Name of Individual, Partnership, Corporation or Organization or Other Legal Entity

B. Type of Organization

☐ Non-Profit

☐ Governmental Agency

☐ For Profit

☐ Sole Proprietorship

☐ Partnership

☐ Corporation

☐ Other (explain)

C. Officers and Members of the Governing Board, including the President of the Board of Directors

NAME	TERM	ADDRESS/PHONE NUMBER	OFFICE HELD

D. Officers and Members of the Advisory Board (if Applicable)

NAME	TERM	ADDRES PHONENUMBER	OFFICE HELD

7. Chief Executive Officer (or other person employed to report to the Governing Body)

NAME	ADDRESS	TELEPHONE	EMAIL

8. Does applicant now own and/or operate or has previously owned and/or operated any other residential child care and treatment facility or child placing agency?

☐ YES ☐ NO

If yes, please give name and location of facility or agency.

NAME	ADDRESS

Have any of the facilities or agencies named above ever been refused a license or had a license revoked?

☐ YES ☐ NO

If yes, please give name of facility or agency and an explanation.

Name of Facility/Agency	Date of Negative Action	Explanation

9. Program Description (Describe the goals of the program, the services to be provided, the daily schedule and the therapeutic model of the program)

10. Will this Program have components for which payment will be billed to Medicaid? (If yes, please indicate your plans to enroll with Molina and the Bureau for Medicaid Services)

11. Describe educational services to be provided.

12. Date of most recent Fire Marshal Inspection(attach copy of report)

13. Date(s) of most recent Environmental Health Inspections (s) (attach copies of both General Sanitation and Food Services reports)

14. New facility applications or amended applications: Life Safety Approval from the Office of Health Facilities Licensure and Certification (OHFLAC) and Certificate of Need (CON) verification (attach copies of approval letter)

15. Describe food services program and provide documentation of assistance from a dietitian in planning the program.

16. Medication Control and Administrations

A. Describe medication control and administration plan or attach policy

B. Provide name(s) of registered or licensed practical nurse(s) responsible for offering nursing services.

17. Health and Behavioral Health Services

A. Describe how health and behavioral health services will be provided for both emergency and routine medical needs or attach a copy of the policy. Provide names and address of all providers.

18. Describe plan to provide recreational activities and programs.

19. Do you utilize student interns and/or volunteers?

☐ **YES**

☐ **NO**

20. Financial Management

A. If initial application, describe plan for ensuring sufficient operating funds for at least six months(attach documents)

B. If renewal application, provide date of last audit and attach copies of annual audit and site specific operating budget, indicating whether it is calendar or fiscal year

C. Verification of liability insurance (78CSR 3, Section 8.7.e.3) (78 CSR 2, Section 12.2.k) (attach documentation)

21. Employed Staff (provide list of current employees)

EMPLOYEE NAME	JOB TITLE	FULUPART TIME	EDUCATION/ CERTIFICATION	DATE OF HIRE	BACKGROUND CHECK (DATE)	CIB DATE	SALARY

22. Contracted Staff (Provide list of current contract staff)

NAME	TITLE	CIB (DATE)	BACKGROUND CHECK (DATE)

23. Declaration and Signature

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(Official name of Facility or Agency)

hereby applies for a license/approval to engage in Residential Child Care and Treatment or Child Care and Treatment or Child Placing

We hereby represent to the West Virginia Department of Health and Human Resources that we are familiar with the standards for residential child care pursuant to the provisions of West Virginia Code §49-2B and that if a license or certificate of approval is issued to us, we will conform to standards as the same now exist or may hereafter be amended.

We herby represent that we have read the foregoing application and know the contents thereof; that the statements concerning the above name center/agency, therein contained, are correct and true of his/her own knowledge.

Signature: ______________________________

Owner or Board President

Date: ______________________________

Signature: ______________________________

Chief Executive Officer

Date: ______________________________

Taken, subscribed and sworn to before me this ____________ day of ____________ ,20 ____

Notary public in and for

______________________________ West Virginia.

My commission expires on the ____________ day of ____________ , 20____

This space is for additional information you would like to provide.