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|  |  **Certified Children’s Residential Services Initial Application** |
| **Section 1. Type of Application** |
| [ ]  **Initial**[ ]  **Change of Ownership\*** (change of business entity ownership or the form of legal organization)\* Certification Number for current provider:  |
| **Section 2. Type of Service Provided** |
| [ ]  Children’s Residential Habilitation (Out-of-Home Services / Residential Habilitation for Dependent Youth)[ ]  Enhanced Respite Services (ERS)[ ]  Licensed Intensive Habilitation Services (IHS)[ ]  State-Operated Community Residential (IHS or SOLA) |
| **Section 3. Information About the Service Provider** |
| 1. Name of Service Provider (Doing Business As)

 |
| 1. Business Street Address City State Zip Code

 |
| 1. Mailing Address (if different from above) City State Zip Code

 |
| 1. Telephone Number

 | 1. Confidential Fax Number

 | 6. Cell Phone Number |
| 1. Email Address

 | 1. Website URL

 |
| **Section 4. Facility** |
| 1. Name of Facility

 |
| 1. Facility Street Address City State Zip Code

 |
| 1. Contact

 |
| 1. Telephone Number

 | 1. Confidential Fax Number

 | 6. Cell Phone Number |
| **Section 5. Administrator Information** |
| 1. Name of Administrator (Last, First, Middle)

 | 1. Date of Birth

 |
| 1. Address City State Zip Code

 |
| 1. Telephone Address

 | 1. Email Address

 |
| **Section 6. Licensed Provider: Please include the following attachments.** |
| [ ]  Contractor Intake Form DSHS 27-043 [ ]  All licensing Policies and Procedures[ ]  A copy of the last DCYF Safety Check |
| **Section 7. To be Completed by DDA Resource Manager or Designee for Licensed Providers** |
| RM mark completion / receipt of:[ ]  Documentation of cleared background check(s) for contract[ ]  DDA Site Visit completed on date: [ ]  DCYF Safety Check or documentation of successful DCYF site visit completed on date:  [ ]  DCYF License number: The DCYF License includes completion of Policies and Procedures and:* Floor Plan
* Emergency procedures and evacuation
* Medication Management
 |
| **Section 8. To be Completed by DDA Resource Manager or Designee for SOCR Providers** |
| [ ]  Site Visit and Safety Check completed on date:  |
| **Section 9. SOCR: Please also include these attachments.** |
| [ ]  Standard Operating Procedures: Emergency procedures and evacuation [ ]  Standard Operating Procedures: Medication Management[ ]  Floor Plan |
| **Section 10. Certification** |
| Completion of this form indicates the provider meets applicable program rules and policies.Date received:  Received by:       |