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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: | | | | | |