

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 LEON SULLIVAN WAY
CHARLESTON, WEST VIRGINIA 25301**

**INITIAL OR RENEWAL APPLICATION
FOR LICENSE TO PROVIDE
BEHAVIORAL HEALTH SERVICES –
SPECIALIZED FOSTER CARE/TRANSITIONAL LIVING
FOR CHILDREN**

INSTRUCTIONS:

Please read carefully and complete this application in accordance with instructions (use typewriter or print legibly with permanent types of ink).

- Application for license may be made by any political subdivision or by any person, association or corporation.
- The application shall be verified before an officer of the State authorized to administer oaths, by the person, or by a member of the firm or association or an officer of the corporation making this application.
- This application must be accompanied by a check or money order payable to the West Virginia Department of Health and Human Resources in the amount of ten dollars (\$10.00).

NAME AND LOCATION

Name of Center/Agency: _____

Administrative Mailing Address: _____

Telephone Number: _____ Fax Number: _____

FEIN#: _____ E-Mail Address: _____

(To be used for the licensure process)

MANAGEMENT AND PERSONNEL OF INSTITUTION

Give exact name of Individual, Partnership, Corporation or Organization Operating Center/Agency:

List Names and Addresses of Any Persons Who, as a Stock Holder or Otherwise, Have a Proprietary Interest of Five (5%) Percent or More in the Center/Agency:

Give Name of Governing Body (Board of Directors, Trustees, Etc.):

List Name and Address of Officers (with titles) and Members of Governing Board:

	Name	Address	Title
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Give Name and Title of Center/Agency Director:

ADMINISTRATIVE OFFICES

Please list all offices with addresses/telephone numbers from which you provide services to children in specialized foster care and/or transitional living:

1. Office: _____ Address: _____ Phone: _____	5. Office: _____ Address: _____ Phone: _____
2. Office: _____ Address: _____ Phone: _____	6. Office: _____ Address: _____ Phone: _____
3. Office: _____ Address: _____ Phone: _____	7. Office: _____ Address: _____ Phone: _____
4. Office: _____ Address: _____ Phone: _____	8. Office: _____ Address: _____ Phone: _____

SPECIALIZED FOSTER CARE

Number of specialized foster care homes by county and number of beds at time of application in this county (attach a separate listing and/or complete as many Page 4s as necessary):

COUNTY	NUMBER OF HOMES	NUMBER OF BEDS

TRANSITIONAL LIVING

Number of transitional living placements by county and number of children currently served from this county (attach a separate listing and/or complete as many page 4s as necessary):

COUNTY	NUMBER OF HOMES	NUMBER OF CHILDREN

APPLICANT

_____, 20____

Signature of Individual/Administrative Officer:

Title or Position:

If other than Individual or Administrative Officer:

Name

Address

VERIFICATION

STATE OF WEST VIRGINIA)
) ss
County of _____)

_____, being by me duly sworn on his/her oath,
deposes and says that he/she has read the foregoing application and knows the contents thereof: that
the statements concerning the above named center/agency, therein contained, are correct and true of
his/her own knowledge.

(Signature of Individual/Administrative Officer)

Subscribed and sworn to before me this

_____ day of _____, 20_____.

Notary Public

My Commission expires _____.