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| If requested information or supporting documentation is not available, a written explanation must be included. | | | | | | | |
| **CHECK THE TYPE OF CHILD WELFARE AGENCY LICENSE YOU ARE APPLYING FOR** | | | | | | | |
| Residential Group Home  Residential Shelter Care | | | | | | | |
| APPLICANT FULL LEGAL NAME: (Last, First, Middle) | | | TITLE: | | | | |
| OTHER NAMES USED: *(Birth name, prior married names, legal changes of name, etc.)* | | | | AGENCY NAME: | | | |
| AGENCY PHYSICAL ADDRESS: (Number, Street, City, State, ZIP) | | | | | | | |
| AGENCY MAILING ADDRESS: (If different from physical address) | | | | | | | |
| AGENCY PHONE: | | AGENCY FAX: | | | FEDERAL TAX ID NUMBER: | | |
| E-MAIL ADDRESS: | | | | | | | |
| AGENCY IS FOR:  PROFIT  NON-PROFIT | | | | | | | |
| LICENSING PREFERENCES:  Male  Female  Both Age Range:       Number of Children: | | | | | | | |
| **LIST ALL FACILITY LOCATIONS** | | | | | | | |
| **LOCATION NAME** | **PHYSICAL ADDRESS**  ***(Number, Street, City, State, Zip)*** | | | | | **PHONE NUMBER** | **ANY STAFF USE AS PRIMARY RESIDENCE?** |
|  |  | | | | |  | Yes  No |

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Tab on the last cell above for more rows to add additional facilities if applicable

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| **CORPORATE OFFICERS / MEMBERS** | | | | | |
| **TITLE** | **NAME** | **ADDRESS** | **PHONE** | **EMAIL** | |
| Applicant |  |  |  |  |  |
| CEO |  |  |  |  |  |
| Acting CEO |  |  |  |  |  |
| Program Director |  |  |  |  |  |
| Manager / Supervisor |  |  |  |  |  |
| Medical Director |  |  |  |  |  |
| 10% Owner |  |  |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

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| **CORPORATE OFFICERS / MEMBERS (CONT’D)** | | | | | | | | | | | | |
| **Title** | **Name** | **List current licenses or certifications held** | **Has this person applied for a license or certification in any state to provide care to a child or vulnerable adult?** | | **Has this person had a license, application, or certification in any state to provide care to a child or vulnerable adult denied or revoked?** | | **Has this person had allegations of abuse or neglect of a child or vulnerable adult?** | | **Has this person been a party to Litigation within the past 10 years? (2)** | | **Has this person operated a child welfare agency in the past 10 years?** | |
| **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| Applicant |  |  |  |  |  |  |  |  |  |  |  |  |
| CEO |  |  |  |  |  |  |  |  |  |  |  |  |
| Acting CEO |  |  |  |  |  |  |  |  |  |  |  |  |
| Program Director |  |  |  |  |  |  |  |  |  |  |  |  |
| Manager / Supervisor |  |  |  |  |  |  |  |  |  |  |  |  |
| Medical Director |  |  |  |  |  |  |  |  |  |  |  |  |
| List all owners with 10% or more ownership        % Owners |  |  |  |  |  |  |  |  |  |  |  |  |
| Other:\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |

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**Tab on the last cell above for more rows to add additional Corporate Officers if applicable**

(1) **If answered yes, a written description shall be submitted with this application**

(2)Business and personal litigation including but not limited to bankruptcy, collections, child support, divorce, dependency criminal proceedings, adoption, child custody, lawsuits, etc. If answered yes, a written description shall be submitted with this application.

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| **GOVERNING BODY** | | | | |
| **NAME** | **ADDRESS** | **POSITION TITLE** | **MEMBERSHIP TERM** | **RELATIONSHIP TO APPLICANT** |
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| **ADULTS RESIDING WITH STAFF IN FACILITY**  **N/A** | | |
| **NAME OF ADULT** | **NAME OF STAFF** | **FACILITY LOCATION** |
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Tab on the last cell above for more rows to add additional adults if applicable

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| **CHILDREN RESIDING WITH STAFF IN FACILITY**  **N/A** | | |
| **NAME OF CHILD** | **NAME OF STAFF** | **FACILITY LOCATION** |
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Tab on the last cell above for more rows to add additional children if applicable, children in care with the department do not apply

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| **ACKNOWLEDGEMENT AND AGREEMENT** | | |
| I hereby swear and affirm, under penalty of perjury, that the foregoing information is true and correct.  I hereby agree that any false information supplied by me in this application or in support of this application shall be sufficient  grounds to deny the application.  I hereby authorize the Arizona Department of Child Safety to investigate me, and agree to cooperate in good faith with the  Department in allowing an authorized Department representative to visit this agency or facility at any reasonable time, announced  or unannounced, to interview such staff, employees, volunteers or other personnel as may be determined necessary by the  Department in conducting its licensing study/investigation.  I agree that the Department may conduct collateral interviews with any source of information regarding this applicant/agency/staff/ facility in the course of the licensing study/investigation. Refusal to allow interviews with any child, employee or staff member  shall be grounds to deny this application.  I further understand and agree that the burden and responsibility to supply all required information and documents rest with me, the  applicant and failure or refusal to supply such information and/or documents shall be grounds to deny this application. | | |
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| APPLICANT NAME PRINTED |  | APPLICANT TITLE |
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| APPLICANT SIGNATURE |  | DATE |
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| **PLEASE RETURN THIS COMPLETED FORM TO** | | |
| **ELECTRONIC MAIL** | **US MAIL** | **PHYSICAL OFFICE** |
| [CWL@azdcs.gov](mailto:CWL@azdcs.gov) | OLR – Child Welfare Licensing  P.O. Box 6030, SC C010-20 Phoenix, AZ 85005-6030 | DCS - OLR Phoenix Corporate Center  3003 N. Central, Suite 108  Phoenix, AZ 85012 |

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| **FOR DCS/OLR USE ONLY** | | |
| DATE REQUEST RECEIVED: | INITIALS: | REQUEST RECEIVED BY: |
|  |  | Mail  Email  In Person  Courier |

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|  |  | Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request. • Ayuda gratuita con traducciones relacionadas con los servicios del DCS está disponible a solicitud del cliente. |