



Minnesota Department of **Human Services**  
**Division of Licensing - Family Systems Unit**

**Application for Family Child Care (FCC), Child Foster Care (CFC),  
 Adult Foster Care (AFC) and Family Adult Day Services (FADS) licensure**

**Instruction:** Use ink and print clearly.

**New license:** Complete all sections.

**Renew license:** Complete sections 1, 2a, 3, 5, 6, 8, 9, and any changes in sections 2, 4 and 7.

**Update license:** Complete sections 1, 2, 2a, 3, 5, 6, 8, 9 and any changes in sections 2, 4 and 7.

**Close license:** Complete sections 1, 3 and 9.

**\* Indicates required sections**

**Dual licenses:** Complete one application form for each program as needed.

**Change of premise:** (Remaining with same licensing agency):

Use existing license number at new address.

**Change of name:** Follow instructions for update.

**1. Action code\***

License number\* (if known) \_\_\_\_\_

Action type\*

- New  Close  
 Renew Date: \_\_\_\_\_  
 Update (**Highlight changes made**) Code: \_\_\_\_\_  
 Change of premise \_\_\_\_\_

Rule\*  CFC  FCC  AFC  FADS

Dual license (requires a variance request and DHS-3324 forms)

- Yes  No  
 CFC  FCC  AFC

Ownership type:

- Individual(s) - The home is the primary residence of the license holder.  
 Corporate - The home is NOT the primary residence of the license holder.

**2. Provider information (corporation, business entity, owner, managerial official or controlling individual)**

COMPANY NAME			
NAME (LAST, FIRST, MI): Print clearly (managerial or controlling individual)		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
STREET ADDRESS			
CITY	STATE	ZIP CODE (9 DIGIT)	
COUNTY	PROVIDER AREA CODE AND PHONE NUMBER		

**3. Facility information\* (site where the services are provided)**

NAME (LAST, FIRST, MI): PRINT CLEARLY (if corporate, list company name)		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
NAME (LAST, FIRST, MI): PRINT CLEARLY		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	D.O.B.
STREET ADDRESS			
CITY	STATE	ZIP CODE (9 DIGIT)	
COUNTY	AREA CODE AND PHONE NUMBER		

**2a. For child foster care only - provider race and ethnicity**

Provider 1 Name _____ <input type="checkbox"/> African American/ Black <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Two or more races <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other	Provider 2 Name _____ <input type="checkbox"/> African American/ Black <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Two or more races <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other	Provider 3 Name _____ <input type="checkbox"/> African American/ Black <input type="checkbox"/> Alaska Native/ American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Two or more races <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other
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**4. Special family child care home information\* (employer, church, community collaborative, not-for-profit agency) Circle one. Please attach required information. See instructions.**

NAME (EMPLOYER, CHURCH, COMMUNITY COLLABORATIVE, NOT-FOR-PROFIT AGENCY)				
CONTACT PERSON: PRINT CLEARLY		STREET ADDRESS		
CITY	COUNTY	STATE	ZIP CODE (9 DIGIT)	AREA CODE AND PHONE NUMBER

**5. License information\***

License classification      License capacity \_\_\_\_\_

**Family child care**

A     Employer  
 B1    Church  
 B2    Community collaborative  
 C1    Not-for-profit agency  
 C2  
 C3    No infants in care  
 D     No transporting children under 9

**Child foster care**

Foster family  
 Foster residence  
 Treatment foster care

**Type of client**

**Adult foster care**

Developmentally disabled  
 Physically disabled  
 Mentally ill  
 Elderly  
 Other

**Child foster care**

Relatives only  
 Relatives and non-relatives  
 Non-relatives only

**6. Dates\* Fill in appropriate dates (month-day-year):**

\_\_\_\_\_ Effective\*                      \_\_\_\_\_ Expiration\*  
 \_\_\_\_\_ BGS\*                              \_\_\_\_\_ Fire inspection

If corporate foster care, name, date of birth, BGS date and study ID number of the highest ranking official:  
 Name \_\_\_\_\_  
 DOB \_\_\_\_\_ BGS date \_\_\_\_\_ DHS Study ID \_\_\_\_\_

**7. Dwelling information**

**Type of residence:**

Single family                       Apartment                       Duplex/twin home  
 Mobile home                       Town house                       Other

Own/rent:                                       Own                       Rent  
 Non-residential:                               Yes                       No  
 Attached garage:                               Yes                       No                       Conditional  
 Basement:                                       Yes                       No                       Conditional  
 First floor                                       Yes                       No                       Conditional  
 Second floor                                       Yes                       No                       Conditional  
 Above second floor                               Yes                       No                       Conditional

Note: Conditional means certain conditions apply to the usage of this area based upon Minnesota Rules, the Minnesota Uniformed Fire Code and other applicable building requirements

**8. Sensitive mailing address for child foster care residence BGS\***

NAME (LAST, FIRST, MI)		
STREET ADDRESS		
AGENCY CITY	STATE	ZIP CODE

**9. Signature\* I have completed the necessary reviews and hereby recommend that the applicant be licensed pursuant to the laws and rules of the state of Minnesota. The provider's signed application, and authorized representative information, is maintained in the agency file.**

SIGNATURE OF AUTHORIZED AGENCY REPRESENTATIVE			DATE
LICENSOR NAME (PRINT)	AGENCY AND LICENSOR CODE	COUNTY OR PRIVATE AGENCY	AREA CODE AND TELEPHONE NUMBER