



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 DIVISION OF REGULATION AND LICENSURE
 SECTION FOR LONG-TERM CARE REGULATION

APPLICATION FOR LICENSE TO OPERATE AN ADULT DAY CARE PROGRAM

<p>RETURN COMPLETED APPLICATION AND APPLICATION FEE TO: Division of Regulation and Licensure Adult Day Care Licensure Program/Fee Receipt Unit P.O. Box 570 Jefferson City, MO 65102-0570</p>	<p>DO NOT WRITE IN THIS SPACE</p> <p><input type="checkbox"/> New Facility <input type="checkbox"/> Renewal</p> <p><input type="checkbox"/> Change of Owner</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">PROVISIONAL LICENSE NO.</td> <td style="width:50%;">ISSUED</td> </tr> <tr> <td>REGULAR LICENSE NO.</td> <td>ISSUED</td> </tr> <tr> <td>EFFECTIVE DATE</td> <td>EXPIRATION DATE</td> </tr> <tr> <td>DATE FEE RECEIVED</td> <td>AMOUNT</td> </tr> <tr> <td colspan="2">CHECK/MONEY ORDER NUMBER</td> </tr> </table>	PROVISIONAL LICENSE NO.	ISSUED	REGULAR LICENSE NO.	ISSUED	EFFECTIVE DATE	EXPIRATION DATE	DATE FEE RECEIVED	AMOUNT	CHECK/MONEY ORDER NUMBER	
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<p>IN ACCORDANCE WITH THE REQUIREMENTS OF SECTIONS 660.400 THROUGH 660.420, RSMO (2000) AND 19 CSR 30-90.080, AN APPLICATION IS HEREBY MADE FOR LICENSURE TO ESTABLISH, CONDUCT OR MAINTAIN AN ADULT DAY CARE PROGRAM AS: (CHECK ONE)</p> <p><input type="checkbox"/> Free Standing Adult Day Care Program</p> <p><input type="checkbox"/> Associated Adult Day Care Program List Name of Associated Organization: _____</p> <p>PROGRAM CAPACITY _____</p>											
<p>1. FEE SCHEDULE - CHECK LICENSE CAPACITY REQUESTED <input type="checkbox"/> 8 or Fewer – \$25.00 <input type="checkbox"/> 9 through 16 – \$50.00 <input type="checkbox"/> 17 through 24 – \$75.00 <input type="checkbox"/> 25 or more – \$100.00</p>											
2. NAME OF ADULT DAY CARE PROGRAM	TELEPHONE NUMBER ()	COUNTY (OR CITY OF ST. LOUIS)									
ADDRESS OF ADULT DAY CARE PROGRAM											
3. IF A CHANGE OF OWNERSHIP, FORMER NAME OF ADULT DAY CARE PROGRAM											
4. TYPE OF PROVIDER OF THE ADULT DAY CARE PROGRAM (CHECK ONE)											
<p>Governmental</p> <p><input type="checkbox"/> City</p> <p><input type="checkbox"/> County</p> <p><input type="checkbox"/> State</p>	<p>Not-For-Profit</p> <p><input type="checkbox"/> Religious Organization</p> <p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Other: _____</p>	<p>Proprietary</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Corporation</p>									
5. NAME OF PROVIDER	TELEPHONE NUMBER ()	COUNTY (OR CITY OF ST. LOUIS)									
ADDRESS OF PROVIDER											
6. NAME, ADDRESS AND PERCENTAGE OF OWNERSHIP OF ANY INDIVIDUAL OR ENTITY WHO OWNS AN INTEREST OF FIVE PERCENT (5%) OR MORE IN THE LAND, STRUCTURE(S), MORTGAGE OR OTHER OBLIGATION, OR LEASE ON WHICH AN ADULT DAY CARE PROGRAM IS BEING CONDUCTED. INDICATE WHETHER THIS OWNERSHIP INVOLVES LAND, STRUCTURE(S), MORTGAGE OR LEASE.											
7. NAME OF ADULT DAY CARE PROGRAM DIRECTOR											
8. HAS THE PROGRAM, PROVIDER DIRECTOR OR ANY CORPORATE OFFICERS, DIRECTORS OR HOLDERS OF FIVE PERCENT (5%) OR MORE STOCK OR OWNERSHIP EVER BEEN CONVICTED OF A MISDEMEANOR RELATING TO THE OPERATION OF AN ADULT DAY CARE PROGRAM, LONG-TERM CARE FACILITY OR OF ANY FELONY?											
<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the person's name and type of conviction: _____</p>											
9. Fire Safety and Facility Physical Requirements (for all initial licensure applications only):											
<p>For Free Standing Adult Day Care Programs submit a diagram of the building that houses the adult day care program. This diagram shall be labeled to show exits; fire extinguishers; smoke detectors and room use, such as dining, crafts, quiet room, therapy or offices. This diagram shall give exact measurements of the area to be used for the adult day care program.</p> <p>For Associated Adult Day Care Programs submit a diagram of the designated space for the adult day care program. This diagram shall show the portion set aside for the adult day care program including office space; dining area; quiet area; craft area; general adult day care meeting area or therapy. This diagram shall give exact measurement of the area used for the adult day care program and also show the locations of exits or entrances for day care; fire extinguishers; and other fire safety features, such as pull stations and smoke detectors.</p>											
10. IS AN ALZHEIMER'S SPECIAL CARE UNIT/PROGRAM A PART OF THIS CENTER?											
<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, then it is required MO Form 580-2637 (2-07), Alzheimer's Special Care Services Disclosure Form, be submitted with this application.)</p>											

11. The fee must be submitted with this application. Enclose a check or money order ONLY payable to the Missouri Department of Health and Senior Services

I hereby affirm that I, as an individual, or the operating corporation or partnership for which I sign, have adequate financial resources to properly construct, equip and operate the adult day care program referred to in this application, and hereby authorize the division to obtain information from third parties verifying this.

I further affirm that I have read, understand and agree to abide by the provisions of sections 660.400 through 660.420, RSMo (2000), and the Adult Day Care Program Licensure rules of the Division of Regulation and Licensure – specifically, 19 CSR 30-90.010 through 19 CSR 30-90.080.

I further affirm that I understand that I am eligible for a license only if the program and the provider are in compliance with the law and the regulations thereunder, and that a license may be revoked at any time that the facility, provider or operator fail to comply with such laws and rules.

I further affirm under the penalties of perjury, that all documents and information required by the division to be filed pursuant to this application are true and correct to the best of my knowledge and belief and that all required documents are either included with the application or are currently on file with the division.

MUST BE SIGNED IN THE PRESENCE OF NOTARY	APPLICANT'S SIGNATURE	DATE
	PRINT OR TYPE NAME	TELEPHONE NUMBER ()

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE	COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	DAY OF	YEAR
	USE RUBBER STAMP IN CLEAR AREA BELOW.	
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	