

Minnesota Department of **Human Services**
 Family Systems Unit -Licensing Division- Office of Inspector General
 CFC 3324- Recommendation for **CHILD FOSTER CARE - Family** Licensure

1. Action Requested

*License Number * _____

* License Type Child Foster Care - Family

*Previous License # (if applicable) _____

* Dual License YES NO (requires a variance request form A18 submitted with 3324)

If yes above: FCC License # _____ AFC License # _____

***Action Type**

NEW (complete all sections)

RENEW (complete 1, 2, 6 and 7)

UPDATE (complete 1, 2, 6, 7 and any changes in 3, 4, 5, and 7)

Circle & highlight other sections where changes are being made: **2 3 4 5 7** Explain: _____

CHANGE OF PREMISE (complete all sections)

CLOSE (complete 1, 2, & 7) Date of Close _____ Closing Code: A B C D E F G H

* Ownership Type: Individual (site where services are provided is the primary residence)

If reason for closure is (H) "Other," explain _____

2. Individual Applicant(s)/Controlling Individual(s)/Authorized Agent(s) (Attach additional pages if needed)

Note: See 2a for Race and Ethnicity Codes

Full Legal Name (Last, First, MI)			Date of Birth (MM/DD/YYYY)	Race	Gender <input type="checkbox"/> M <input type="checkbox"/> F	DHS Background Study ID#
Street Address (and PO Box if required for mail delivery)			City	State	Zip	Area Code and Phone Number
County	Social Security # (initial application only)	MN Tax ID # (if applicable)	Federal Tax ID # (if applicable)		Email Address	
Full Legal Name (Last, First, MI)			Date of Birth (MM/DD/YYYY)	Race	Gender <input type="checkbox"/> M <input type="checkbox"/> F	DHS Background Study ID#
Street Address (and PO Box if required for mail delivery)			City	State	Zip	Area Code and Phone Number
County	Social Security # (initial application only)	MN Tax ID # (if applicable)	Federal Tax ID # (if applicable)		Email Address	

2a. Use to complete Race/Ethnicity in Section 2

AFB- African American/Black
ANAI- Alaska Native/American Indian
White- White

Asian- Asian
Hispanic- Hispanic
Other- Other

NHPI- Native Hawaiian or other Pacific Islander
TMR- Two or More Races

3. Compliance Officer	Check if not applicable
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Name (Last, First, MI) and Title/Position			
Address (Street address preferred, PO Box is acceptable)	Email Address	Telephone Number	
City	County	State	Zip Code

4. License Information	5. Dwelling Information
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License Classification License Capacity: _____

Does program provide treatment foster care? Yes No

Individuals served by program (check ONE):
 Relatives Only Relatives & Non-Relatives
 Non- Relative Only

Type of Residence

Single Family	Apartment/Condo	Duplex/Twin Home
Mobile Home	Townhome	Other

Own/ Rent: Own Rent

Non- Residential: Yes No

Attached Garage: Yes No Restricted Use

Basement Yes No Restricted Use

First Floor: Yes No Restricted Use

Second Floor: Yes No Restricted Use

Above Second Floor: Yes No Restricted Use

NOTE: Restricted use means certain conditions apply to the use of this area based on Minnesota Rules, the Minnesota Uniform Fire Code and other applicable building requirements.

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

____/____/____ Effective Date

____/____/____ Expiration Date

____/____/____ Fire Inspection (if required)

7. 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 providers signed application, and authorized representative information is maintained in the agency file.

Signature of Agency Authorized Representative	Licensor Name (Print)	Date	
Email Address	Agency and Licensor Code	County or Private Agency	Area Code and Phone Number

* For a new license, you must attach the Supplemental BGS Form