

LICENSE APPLICATION

Family Adult Foster Care (AFC); Family Adult Day Services (FADS) AFC Alternate Overnight Supervision Technology

Minnesota Department of Human Services, Office of Inspector General, Licensing Division

Date of Application: _____

(Please type or print using black or blue ink. All areas must be completed)

1. License Type: (check all that apply)

- Family (Individual) AFC** – the program is operated in your home **FADS**
 AFC Alternate Overnight Supervision Technology

Check One: New Renewal Update Change of Premise

For all NEW APPLICATIONS for licensure submitted January 1, 2026 or later, there will be a \$2100 application fee due prior to the application being reviewed by the county. You will receive an invoice from the Department of Human Services (DHS) to the email address you provide below. This application fee must be paid within 30 days of the invoice date. If you do not pay the application fee within 30 days of the invoice date, it will be considered that you have voluntarily withdrawn your application, and your application will be removed from queue.

2. License holder information:

Full Legal Name of Applicant (Last, First, Middle)			Date of Birth
Street Address (and PO Box if required for mail delivery)			
City	County	State	ZIP
Telephone Number	Email Address		
Full Legal Name of Applicant (Last, First, Middle)			Date of Birth
Street Address (and PO Box if required for mail delivery)			
City	County	State	ZIP
Telephone Number	Email Address		

3. License History:

Are you currently or have you ever been licensed? Yes (complete below) No

Type of License (check all that apply) <input type="checkbox"/> Community Residential Setting	
<input type="checkbox"/> Family Child Care <input type="checkbox"/> Child Foster Care <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> FADS <input type="checkbox"/> Other _____	
License Number	County/ Agency/ State
Effective Dates of License	

Have you ever had a DHS license denied or revoked? Yes No

If yes, list the date of denial or revocation and license type or the license number

Date of License Denial or Revocation	License Type for Denied License or License #
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Do you currently hold a 245D Home & Community Based Services (HCBS) License? Yes No

If yes, provide your 245D HCBS License Number: _____

4. Tax identification information:

The license holder is the business entity that is responsible for the license. The Minnesota Human Services Licensing Act makes a distinction between "individual" and "nonindividual" license holders.

An individual license holder is generally a **sole owner** or **sole proprietorship** where the business is owned and run by one or more person(s). The license holder is not a corporation, partnership, voluntary association, or other organization or government entity, and there is no legal distinction between the owner and the business.

Individual applicants and license holders are required to provide tax identification (ID) information including Federal Employer ID Number (FEIN), and/or Minnesota Tax ID Number, if you have either. Individual applicants and license holders must also provide their Social Security Number (SSN). Tax ID information is not public; however, DHS is required to provide the tax ID and the SSN of each license holder to the Minnesota Department of Revenue.

Under the Minnesota Government Data Practices Act, we must advise you that:

- i. This information may be used to deny the issuance of a license, or to revoke a license, if you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest.
- ii. DHS will only provide the tax identification information to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Act, the Department of Revenue is allowed to supply this information to the Internal Revenue Service.

MN Tax ID (if you have one)	SSN(s) for each individual applicant	Federal Employer ID (FEIN) (if you have one)
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5. Authorized Agent information

You must designate one individual applicant to act as the authorized agent. The agent is authorized to accept service on behalf of all of the individual license holders of the program. Service on the agent is service on all of the individual license holders of the program. It is the responsibility of the authorized agent to ensure that any mail received from DHS is distributed as needed and a response provided within stated timelines when required.

Who is the authorized agent for your program? (required only for new applicants or if changing the authorized agent)	
FULL NAME	EMAIL

6. Dwelling Information (check all that apply)

- Owned Rented
- Single Family Home Duplex/Twin home Apartment/Condo Townhome Mobile Home Other
- Basement First Floor Second Floor Above Second Floor
- Attached Garage Wood Burning Stove/Fireplace

7. Individuals Living in the Program (Do not include individuals receiving licensed services)

Check this box if not applicable

Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date
Name (Last, First, MI)	Relationship	Gender	Birth Date

8. References (Required at initial licensure for AFC and FADS programs only, not required if adding a FADS license to an existing AFC license)

Check this box if not applicable

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

Name (Last, First, MI)		
Street Address	Telephone Number	
City	State	Zip Code

9. Population Served - AFC applicants only must complete this section

Check this box if not applicable

Licensed Capacity (indicate number of individuals served by your program):	
Population Served (check all that apply)	
<input type="checkbox"/> Persons with a developmental disability <input type="checkbox"/> Persons with a physical disability <input type="checkbox"/> Persons with a brain injury	<input type="checkbox"/> Persons with chemical dependency <input type="checkbox"/> Persons with a mental illness <input type="checkbox"/> Elderly
Gender Served	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Either	

10. FADS applicants only must complete this section

Check this box if not applicable

Licensed Capacity (indicate number of individuals served by your program):	
Daily Hours of Operation:	
Monday _____	Friday _____
Tuesday _____	Saturday _____
Wednesday _____	Sunday _____
Thursday _____	

11. AFC Alternate Overnight Supervision Technology applicants only must complete this section

Check this box if not applicable

(Submit documentation of items required on the Alternate Overnight Supervision Technology Checklist)

Response Alternative	
<input type="checkbox"/> 1 (one) <input type="checkbox"/> 2 (two)	
Name of county where program is located	Telephone Number

12. Municipality. Required at initial licensure and for change of premise. (Not required for FADS stand-alone programs)

Check this box if not applicable

Applicants for a residential program license issued by the Department of Human Services under Minnesota Statutes, Chapter 245A, the Human Services Licensing Act, are responsible for contacting the municipality where the program will be located to ask about local ordinance requirements. The license applicant is responsible for taking all necessary actions as directed by the municipality to comply with local ordinance requirements. Please document the following regarding your contact with the local municipality.	
Name of Municipality	Date of Contact
Name of Official	Telephone Number

13. Workers compensation insurance verification:

You must complete and submit the *Certificate of Compliance Minnesota Workers' Compensation Law MN LIC 04* form with your license application. Under section 176.182 DHS is prohibited from issuing a license until the applicant presents evidence of compliance with the worker's compensation insurance requirement.

Minnesota workers' compensation law requires all employers to purchase workers' compensation insurance or become self-insured. For information on workers' compensation insurance requirements go to the Minnesota Department of Labor and Industry website at: <http://www.dli.mn.gov/WorkComp.asp>.

14. Applicant acknowledgement of public funding reimbursement for licensed services:

DHS license holders who elect to receive *any* public funding reimbursement (including Medical Assistance) for licensed services, must acknowledge that they will comply with funding requirements, that compliance with those requirements may be monitored by DHS Licensing, and that they know the consequences for noncompliance with those requirements (Minnesota Statutes, section 245A.04, subdivision 1).

- I do elect** to receive public funding reimbursement for the licensed services and will comply with all requirements.
- I do not elect** to receive public funding reimbursement for the licensed services.

By signing below:

I acknowledge that the information I have provided on this application is complete and true. I agree that:

- The commissioner's representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect my home and its grounds at any time.
- The documentation and inspection required by the rules are necessary for the commissioner to determine whether I am complying with Minnesota Rules and Laws.
- Any documentation that I provide or representations that I make to the commissioner's representative during the time that I am licensed, or throughout the adoption process, or during the license application process will be complete and true and that any misrepresentations or other violations of Minnesota rules and laws may result in immediate suspension, revocation or denial of the license.

I understand that failure to provide complete and true information on this application may result in denial of my application or revocation of my license.

APPLICANT 1 SIGNATURE	DATE
APPLICANT 2 SIGNATURE	DATE

15. Applicant Agreement, Acknowledgement and Verification Form

At initial application only: The authorized agent must review and approve the license application by signing below. **The signature must be made in the presence of a notary public.** An original notarized copy of the Applicant Agreement, Acknowledgement and Verification Form is required.

For license renewals, updates, change of premise: Notarization is not required. The authorized agent must review and approve the license application and must sign and date the application.

By signing below, I agree that the information that I have provided on this application form is true, accurate and complete. If the Commissioner of Human Services grants me a license, I agree to comply with the requirements in Minnesota Statutes, chapter 245A and all applicable laws and rules, at all times during the terms of the license. I acknowledge that the Commissioner’s representative has the right to request any documentation required by Minnesota Rules or Laws and to inspect the facility/service at any time during the hours that services are provided. I acknowledge that the documentation and inspection required by statutes and rules is necessary for the Commissioner to determine whether I am complying with Minnesota Rules and Laws. I understand that the Commissioner may fine, suspend, revoke or make conditional, or deny a license if an applicant or a license holder fails to comply fully with the applicable laws or rules, or knowingly withholds relevant information from or gives false or misleading information to the Commissioner in connection with an application for a license or during an investigation.

Authorized Agent:

I, _____ (*print full legal name*) state that I am the authorized agent for the license holder identified above. I understand that, by signing below, I am responsible for dealing with the commissioner of human services on all matters provided for in Minnesota Statutes, chapter 245A. I also understand that service of all notices and orders affecting any license held by the License Holder identified above may be made on me, in accordance with Minnesota Statutes, section 245A.04, subdivision 1.

State of Minnesota, County of _____
Signed or attested before me on (Date) _____
Signature of notarial official _____

Signature
(sign in front of notary public at initial application)

Signature
(license renewal, update or change of premise)

Date
(license renewal, update or change of premise only)