APPLICATION FOR CHILD PLACING AGENCY LICENSE (LCPA)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 886 (2-2022)

Clear Fields

Licensure Type
☐ Initial Application
☐ Renewal Application

Name of Agency			Telephone Number
Name of Director			
Address (include street address and mailing address)	City	State	ZIP Code
Physical Address (no PO Box)	City	State	ZIP Code
Mailing Address (if different from above)	City	State	ZIP Code
E-mail Address			Fax Number

We attach the following:

1. Copy of current operating budget (whether by calendar or fiscal year).
2. Copy of most recent fiscal audit.
3. Copy of new or changed policies since last licensure.
4. Agency personnel list (Attachment "A").
5. If this is not an initial application for licensure as a Child Placing Agency-Foster Care, "Attachment B" and/or Adoption "Attachment C".
6. Names/addresses of members of governing body and advisory committees.
7. Current General Comprehensive Liability Insurance Certificate.

Carrier	Policy Number	Term

8. Current Vehicular Liability Insurance Certificate.

Carrier	Policy Number	Term

9. Completed Licensing Checklists: Administration, Personnel, Services, Adoption.
10. List of foster care placements as required by NDCC 50-12-07 and NDAC 75-03-36.

Licensure is requested for the period: From To	Number of children who will be placed by the licensee per year during the licensing term:
The maximum number of children who will be in placement at any one time:	The agency will provide primarily: ☐ Adoption ☐ Foster Care
Geographic Area Served	Average Caseload for Assigned Worker

Certification

I hereby certify:

A. That the information contained in the application is true to the best of my knowledge and I grant permission for this information to be verified with the appropriate persons or agencies.

B. That in accordance with Federal Executive Order # 125490, this facility is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by and federal department or agency from participating in covered transactions.

A covered transaction means a contract, oral or written agreement, grant or any other arrangement where a contractor receives federal money from the state or other agency.

We request the Department of Human Services to complete a licensure study.

Agency Signature	Title	Date
Notary Signature	Stamp	Date

ATTACHMENT "A"

Licensure is requested for the period: From To	Agency Name:

Agency Personnel: Include only employees working **directly** with the LCPA licensed program who have been employed with your agency during the dates of the Licensing Review Period.

LAST NAME, FIRST ** List in alphabetical order by last name	BIRTHDATE	DEGREE AND FIELD	PROFESSIONAL LICENSURE STATUS	POSITION	INDICATE IF FT OR PT (PT-LIST HRS/WK)	DATE OF HIRE	DATE OF TERMIN-ATION	APPROVAL DATE OF FINGERPRINT BASED CRIMINAL BACKGROUND CHECK	DATE OF ANNUAL C/AN (SFN 433)

Attach additional sheets as needed

ATTACHMENT "A"

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Attach additional sheets as needed

FOSTER CARE SERVICES
ATTACHMENT "B"

Name of Agency	Date

☐ I attest that our agency will submit foster care program data as determined by the Department. Including data specific but not limited to the number of licensed providers by level of care, current placements, age of clients, placement disruptions, placement terminations and reasons for disruptions or terminations.

Briefly describe any current changes in your foster care program and future plans.

Describe your supervision process, including frequency of supervision offered to the staff providing foster care services.

ADOPTION SERVICES
ATTACHMENT "C"

Name of Agency	Date

☐ I attest that our agency will submit adoption program data as determined by the Department. Including data specific but not limited to the children placed for adoption, adoption assessments, temporary placements and adoption disruptions.

Briefly describe any changes in the past year in your agency's adoption program and future plans you may implement.

Describe any change in the supervision offered to placement worker staff providing birth parent counseling and adoption services. Attach an organizational chart.

Describe any changes to your agency's assessment process, including group meetings you facilitate. Attach an outline of the group meeting, if changed.

Describe any changes to your agency's evaluation of services. Attach copies of survey instruments. Explain how outcomes influence practice and give any example of such within the last year.

Describe training provided to staff during the last year, specific to adoption practice.
Explain any changes in fee structure and provide a breakdown of budget items used to determine any fee increases.