# APPLICATION FOR SUPERVISED INDEPENDENT LIVING (SIL)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 887 (11-2024)

Clear Fields

☐ One Year License
☐ Two Year License

| Name of Agency | | Telephone Number | |
|---|---|---|---|
| Name of Administrator (ND Administrative Code 75-03-41-12) | | | |
| Address (include street address and mailing address) | City | State | ZIP Code |
| Email Address | | Fax Number | |

We attach the following:

1. Copy of current operating budget.
2. Copy of new or changed policies since last licensure.
3. Names/addresses of members of governing body and advisory committees.
4. Current General Comprehensive Liability Insurance Certificate.

| Carrier | Policy Number | Term |
|---|---|---|
| | | |

5. Current Vehicular Liability Insurance Certificate.

| Carrier | Policy Number | Term |
|---|---|---|
| | | |

6. Completed Licensing Checklists: Administration, Personnel, and Services.

| Licensure is requested for the period:<br>From: To: | Geographic Area of North Dakota Served |
|---|---|
| Ages of Eligible Clients Include<br>From: To: | The agency will provide (ND Administrative Code 75-03-41-20)<br>☐ Independent Apartment ☐ Share Housing<br>☐ College Dorm Room<br>☐ Other (specify:) _____ |
| Maximum number of clients service at one time in SIL | |

**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 # 12549, 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 Health and Human Services to complete a licensure study.**

| Agency Signature | Title | Date |
|---|---|---|
| Notary Signature | Stamp | Date |

## ATTACHMENT "A"

| Licensure is requested for the period:<br>From: To: | Agency Name |
|---|---|

Employees and non-employees: Include only employees and non-employees working **directly** with the SIL licensed program who have been employed with your agency during the dates of the Licensing Review Period.

| LAST NAME, FIRST<br>** 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) |
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Attach additional sheets as needed

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