



APPLICATION FOR CERTIFICATION OF SHELTER CARE PROGRAM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHILDREN AND FAMILY SERVICES

SFN 1728 (5-2024)

☐ Initial Certification

☐ Renewal

Name of Agency					
Physical Address			Business Office Address		
City	State	ZIP Code	City	State	ZIP Code
Telephone Number			Telephone Number		
Email Address			Email Address		
Supervisor of Shelter Care Operations			Contact Person	Title	

Bed Capacity	Ages From: To:	Number of Males	Number of Females	Total
Renewal Certification Only				
Requested Bed Capacity	Ages From: To:	Number of Males	Number of Females	Total
Certification Expiration Date				

Attach a copy of the following:

1. A detailed plan for the operation of the shelter;
2. Written policy to comply with 75-03-14.1 (if renewal only show new policy)
3. Copy of the floor plan with dedicated sleeping spaces;
4. General comprehensive liability insurance coverage;

Carrier	Policy Number	Term
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5. Vehicular liability insurance:

Carrier	Policy Number	Term
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6. Inspection Reports:

<input type="checkbox"/> Fire <input type="checkbox"/> HHS Food and Beverage <input type="checkbox"/> Other _____

7. Employee Checks (Completed by HHS);

- a. Initial fingerprint based criminal background checks
- b. Annual Child Abuse and Neglect checks

8. Completed Policy Checklists;

9. Attach any other documentation related to your agency which is required by NDCC Chapter 50-11 or North Dakota Administrative Code Chapter 75-03-14.1.

CERTIFICATION

I hereby certify:

- a. I have read and have a copy of the North Dakota Administrative Code, Chapter 75-03-14.1
- b. That the information contained in this 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.
- c. That this agency, in accordance with Federal Executive Order #12549, is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any 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 inspect/conduct a certification study to verify compliance with requirements.

Signature	Title	Date
Agency Name		

Certification Review	Facility Name
From: To:	

[illegible]

State Office Use Only:

(Attach additional sheets as needed)

Employee List C/AN (annual) and CB Checks (once upon hire) Verified in HHS File By (Signature)
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Certification Review	Facility Name
From: To:	

[illegible]

State Office Use Only:

(Attach additional sheets as needed)

Employee List C/AN (annual) and CB Checks (once upon hire) Verified in HHS File By (Signature)
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