State of Illinois
Illinois Department of Public Health

INITIAL APPLICATION FOR CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER LICENSE

☐ $500 Application Fee Attached

☐ $100 for each CC-BHCC bed

Total $ _____

CHILDREN ID Number: _____

- DEPARTMENT USE ONLY-

Pursuant to Section 265 of the Alternative Health Care Delivery Act [210 ILCS 3] and the rules of the Illinois Department of Public Health entitled "Children's Community-Based Health Care Center Program Code" (77 Ill. Adm. Code 260)

1. NAME/ADDRESS OF APPLICANT

Name _____

Address _____

City _____ State _____ Zip Code _____ County _____

Telephone Number (Including Area Code) _____

2. LOCATION OF CHILDREN'S COMMUNITY-BASED HEALTH CARE CENTER

Name _____

Address (if different than #1) _____

City _____ County _____ State _____ Zip Code _____

Telephone Number (Including Area Code) _____

3. Maximum Occupancy of the Children's Community-Based Health Care Center _____

4. Name and address of the Illinois Registered Agent or other individual(s) authorized to receive Service of Process for the facility.

Name(s) of Registered Agent(s)	Address

IMPORTANT NOTICE

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER 210 ILCS 3. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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5. List the name(s) and title(s) of person(s) under whose management or supervision the Children's Community-Based Health Care Center beds will be operated.

Name	Title

6. The following must be included with the initial application

- ☐ A. Precise description of the site in accordance with the requirements of Section 260.1200 (a)(4). (Identify as Exhibit I)
- ☐ B. Documentation of compliance with Section 260.2300. (Identify as Exhibit II)
- ☐ C. Admission policies and procedures in accordance with Section 260.1800. (Identify as Exhibit III)

7. VERIFICATION

I (we) swear or affirm that this application and accompanying documents are true and complete. I (we) further certify that I (we) have knowledge of and understand the action required to comply with the Act and licensing requirements.

Signed _____ Signed _____

Title _____ Title _____

Signed and Sworn (or attested) to before me this _____ day of _____ 20 _____

_____
Notary Public

My commission expires _____ 20 _____

SUBMIT APPLICATION AND FEE TO:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION HEALTH CARE FACILITIES AND PROGRAMS
525 WEST JEFFERSON STREET, 4th Floor
SPRINGFIELD, ILLINOIS 62761