



**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

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**