CCL 25R
Revised 07/2026

LOUISIANA DEPARTMENT OF CHILDREN AND FAMILY SERVICES
LICENSING SECTION
P.O. BOX 3078, BATON ROUGE, LA 70821
225-342-4350

APPLICATION FOR LICENSE TO OPERATE A RESIDENTIAL HOME, CHILD PLACING AGENCY, OR MATERNITY HOME.

1. IMPORTANT NOTES

A License is required **PRIOR** to opening. Refer to applicable standards for required fees. All fees are to be paid by **CERTIFIED CHECK OR MONEY ORDER** made payable to the **Department of Children and Family Services**. **Do NOT send cash, business or personal checks.** Fees are **NON-REFUNDABLE. All application sections must be completed in their entirety.**

2. TYPE OF LICENSE

(Check One Only)	**(Check All Appropriate)**
☐ Initial Application	☐ Change of Ownership
☐ Renewal Application for License #:	☐ Change of Location

3. FACILITY/AGENCY INFORMATION

Facility/Agency Name:

Location Address:

Street City **LA** State Zip Code

Mailing Address:

City State Zip Code

Facility/agency Telephone #:	**Office Telephone Number:**	**Parish:**
( ) -	( ) -	

Facility/Agency E-Mail Address (may list multiple email addresses):

4. ORGANIZATIONAL STRUCTURE

Check only one organization structure type (individual, partnership, church, university, corporation/LLC or governmental):

☐ **Individual** – *Sole proprietor or sole owner* is the individual who directly owns a facility/agency without setting up or registering a corporation/LLC, partnership, etc.

Name of Individual: _____ Email: _____

Individual's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Individual's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Individual's Telephone #: _____

Name of Individual's Spouse (if applicable) : _____

Spouse's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Spouse's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Spouse's Telephone #: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

☐ **Partnership** – any general or limited partnership licensed or authorized to do business in this state. Owners of a partnership are its limited or general partners and any managers thereof. (If additional partners, attach separate list to application.)

Name of Partner 1: _____

Partner 1's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Partner 1's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Partner 1's Telephone #: _____

Name of Partner 2: _____

Partner 2's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Partner 2's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Partner 2's Telephone #: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

☐ **Church**

Name of Church: _____

Church's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Church's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone #: _____ Contact Name: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

☐ **University**

Name of University: _____ Department: _____

University's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

University's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone #: _____ Contact Name: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

☐ **Corporation/LLC** – any entity incorporated in Louisiana or incorporated in another State, registered with the Secretary of State in Louisiana, and legally authorized to do business in Louisiana.

Name of Corporation: _____

Corporation's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Corporation's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone #: _____ Contact Name: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

☐ **Governmental** – If governmental, please specify which: ☐ Federal ☐ State ☐ City ☐ Parish

Name of Governmental Entity: _____ Department: _____

Governmental Entity's Physical Address: _____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

Governmental Entity's Mailing Address: _____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone #: _____ Contact Name: _____

☐ Profit or ☐ Non-Profit Federal EIN: _____ State Tax ID#: _____

5. CRIMINAL BACKGROUND CHECKS & STATE CENTRAL REGISTRY REQUIRED

DOCUMENTATION OF SATISFACTORY CRIMINAL BACKGROUND CHECKS AND STATE CENTRAL REGISTRY CLEARANCES MUST BE ATTACHED FOR ALL OWNERS (AS DEFINED ACCORDING TO THE RESPECTIVE REGULATIONS FOR YOUR PROGRAM) AND THEIR NAMES LISTED BELOW.

Individual ownership:

Individual's Name: _____ Spouse's Name: _____

Partnership ownership:

Partner's Name: _____ Partner's Name: _____

Partner's Name: _____ Partner's Name: _____

Church, **Governmental**, entity or **University** owned:

Name _____ Title _____

_____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

_____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone Number: _____

Name _____ Title _____

_____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

_____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone Number: _____

Name _____ Title _____

_____ (Physical Street Address) _____ (City) _____ (State) _____ (Zip Code)

_____ (Mailing Address) _____ (City) _____ (State) _____ (Zip Code)

Telephone Number: _____

Corporation/LLC owned:

Name ______________________ Title ______________________

Physical Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Telephone Number: ______________

Name ______________________ Title ______________________

Physical Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Telephone Number: ______________

Name ______________________ Title ______________________

Physical Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Telephone Number: ______________

Name ______________________ Title ______________________

Physical Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Telephone Number: ______________

Name ______________________ Title ______________________

Physical Street Address | City | State | Zip Code

Mailing Address | City | State | Zip Code

Telephone Number: ______________

Effective October 1, 2018, if an individual is registered as an officer of the board with the Louisiana Secretary of State and/or is listed on the Licensing application, but is not considered to be an owner for licensing purposes according to the respective regulations for your program, a signed, dated DCFS approved attestation form shall be submitted annually attesting to such.

6. PROGRAM INFORMATION

NOTE: IF MORE THAN ONE FACILITY, PROGRAM, OR AGENCY IS TO BE LICENSED, A SEPARATE APPLICATION MUST BE COMPLETED FOR EACH LICENSE REQUESTED.

I/We hereby apply to be licensed as:

☐ **Residential Home**

Choose Type IV OR Class B:

☐ ***Type IV (Formally Class A)*** ***or*** ☐ ***Class B***

☐ ***Accepts Children of Residents***

Licensed Capacity (Proposed, if new facility): _____ Gender Served: ☐Male/ ☐Female/ ☐Both

Age Range of Residents: _____ ☐ Months or ☐ Years To _____ ☐ Months or ☐ Years
(may not exceed 20 years)

Number of Buildings Used by Children/Youth: _____

Name of Buildings - Provide the name or description of each building used (ex. LSU Cottage or Unit A):

Building Name: _____ Capacity:_____ Building Name:_____ Capacity:_____

Building Name:_____Capacity:_____ Building Name:_____ Capacity:_____

Building Name:_____Capacity:_____ Building Name:_____ Capacity:_____

☐ **Maternity Home**

Licensed Capacity (Proposed, if new facility): _____ Number of Buildings Used by Residents/infants: _____

Age Range:
_____☐ Months or ☐ Years To _____☐ Months or ☐ Years Gender Served: ☐Male/ ☐Female/ ☐Both
(may not exceed 20 years)

☐**Child Placing Agency**

Office Days and Hours of Operation (check all days that apply and indicate hours of operation for each day)

Day of the Week	Begin Time			End Time		
☐ Monday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Tuesday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Wednesday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Thursday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Friday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Saturday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	
☐ Sunday	_____ ☐ am	☐ pm	***TO***	_____ ☐ am	☐ pm	

If operational hours differ during the year, please provide explanation below.

Choose one or more subprogram(s) of:
(age range may not exceed 20 years)

☐ ***Foster Care Services***
Age Range: _____☐ Months or ☐ Years To _____☐ Months or ☐ Years

☐ ***Adoption Services***
Age Range: _____☐ Months or ☐ Years To _____☐ Months or ☐ Years

☐ ***Transitional Placing Services (section 7 must be completed)***

Age Range: _____ TO _____ Years
Gender Served: ☐Male/ ☐Female/ ☐Both

7. Child Placing Agency – Transitional Placing Services

NOTE: THIS SECTION IS ONLY REQUIRED TO BE COMPLETED FOR TRANSITIONAL PLACING SERVICES. PLEASE PROVIDE EACH PHYSICAL LOCATION WHERE TRANSITIONAL PLACING SERVICES WILL BE PROVIDED. IF ADDITIONAL PHYSICAL LOCATIONS ARE ADDED THROUGHOUT THE YEAR, WRITTEN NOTIFICATION TO AND APPROVAL FROM LICENSING IS NEEDED PRIOR TO OCCUPYING THE SPACE.

Location 1: _____ _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ Years Gender Served: ☐Male/☐Female

Location 2: _____ _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ Years Gender Served: ☐Male/☐Female

Location 3: _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ Years Gender Served: ☐Male/☐Female

Location 4: _____ _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ Years Gender Served: ☐Male/☐Female

Location 5: _____ _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ or Years Gender Served: ☐Male/☐Female

Location 6: _____ _____ _____ _____ _____
Physical Street Address | City | State | Zip Code | Capacity

Age Range: _____ Years To _____ Years Gender Served: ☐Male/☐Female

8. FACILITY/AGENCY DIRECTOR/ADMINISTRATOR

DOCUMENTATION OF A SATISFACTORY CRIMINAL BACKGROUND CHECK AND STATE CENTRAL REGISTRY CLEARANCE MUST BE ATTACHED FOR THE INDIVIDUAL LISTED BELOW. DIRECTOR/ADMINISTRATOR MUST MEET THE QUALIFICATIONS PRIOR TO BEING APPOINTED.
DOCUMENTATION MUST BE SUBMITTED TO THE LICENSING SECTION TO VERIFY THAT QUALIFICATIONS ARE MET.

The **facility/agency's director/administrator** – the individual who is responsible for the day-to-day operation, management, and administration of the facility/agency as recorded with the Licensing Section.

Name: _____ _____ _____ _____
Title (Examples are Mr., Mrs., Ms., Rev., Sr., Pastor. Other titles not listed here are acceptable.) | First Name | Middle Name | Last Name

Business Email: _____

Home Physical Address: _____ _____ _____ _____
Physical Street Address | City | State | Zip Code

Home Mailing Address: _____ _____ _____ _____
Mailing Address | City | State | Zip Code

Home Telephone Number: ( ) -

Years of Experience in a Licensed Facility/agency:

Date Hired at This Facility/agency in Any Capacity:

Date Hired as Director/Administrator:

Director/Administrator responsible for other facilities/agencies?
☐ No ☐ Yes If yes, list facilities/agencies below:

9. PERSONAL CHARACTER REFERENCES FOR DIRECTOR/ADMINISTRATOR

(REFERENCES SHALL NOT BE RELATED TO DIRECTOR/ADMINISTRATOR)
THIS SECTION IS TO BE COMPLETED FOR ALL INITIAL APPLICATIONS AND WHENEVER THERE IS A CHANGE IN DIRECTOR/ADMINISTRATOR.
PLEASE LIST A MINIMUM OF THREE REFERENCES.

PERSONAL CHARACTER REFERENCES FOR DIRECTOR/ADMINISTRATOR

Name	Mailing Address (including zip code)	Phone Number
		( ) -
		( ) -
		( ) -

10. FUNDING SOURCE (Check all that apply)

☐ Department of Children and Family Services (DCFS)
☐ Dept. of Corrections (OJJ)
☐ Private Pay
☐ Other – Describe:

11. REASONABLE AND PRUDENT AND PARENT STANDARDS REQUIRED FOR RESIDENTIAL HOMES, CHILD PLACING AGENCIES PROVIDING TRANSITIONAL PLACING SERVICES, AND MATERNITY HOMES.

In accordance with Public Law 113-183 and Act 124 of the 2015 Regular Legislative Session, each facility/agency shall designate a representative who is authorized to apply the reasonable and prudent parent standard to create more normalcy for children in the foster care system.

Name of Authorized Representative(s):

12. DECLARATION STATEMENTS - CERTIFICATION BY OWNER OR DIRECTOR/ADMINISTRATOR REQUIRED

I understand that a licensing inspection will be made by the Licensing Section, the State Fire Marshal, the Office of Public Health, and other local agencies as may be appropriate (Zoning, City Fire, etc.).

ALL AGENCIES MUST GIVE THEIR APPROVAL PRIOR TO LICENSURE AND OCCUPANCY.

I certify that I have personally completed this application and have carefully investigated all facts necessary to complete this application. I further certify that all information contained in this application is true and correct to the best of my knowledge and ability. I understand that knowingly providing false information on this application may cause the application to be denied or the license revoked or not renewed. I further understand that failure to provide complete information may result in the application being delayed, denied or the license revoked or not renewed. I also understand that knowingly providing false information may result in criminal charges. I understand that failure to comply with the law and regulations governing the licensure of residential homes, child placing agencies, maternity homes, or juvenile detention facilities could result in the application being denied or license being revoked or not renewed.

Date:

Signature of Owner or Director/Administrator:

Type or Print Name and Title:

DISCLOSURE FORM FOR BACKGROUND INFORMATION		
Name of Facility:		
Physical Address of Facility/agency: Street City **LA** State Zip Code		
License number:		
Yes ☐	**No** ☐	**1.** Has the owner, director/administrator, or any staff ever been convicted of, or pled guilty or *nolo contendere* to any felony? If your answer is "Yes", please provide the name of the person, person's position, the offense convicted of/pled to, the date of the offense, the city and state where the offense occurred, the court handling the case, the date of the conviction/plea, and the sentence imposed.
Yes ☐	**No** ☐	**2.** Has the owner, director/administrator, or any staff ever been convicted of, or pled guilty or *nolo contendere* to any misdemeanor involving a juvenile, elderly, or infirm victim? If your answer is "Yes", please provide the name of the person, person's position, and the offense convicted of/pled to, the date of the offense, the city and state where the offense occurred, the court handling the case, the date of the conviction/plea, and the sentence imposed.
Yes ☐	**No** ☐	**3.** Has the owner, director/administrator, or any person named on the application ever used, or been known by, any name other than that listed, including any maiden name, former married name, legally changed name, or alias? If your answer is "Yes", please provide the present name of that person, each other name used, the dates that other name/names were used, and the reason for the name change (e.g., marriage, divorce, court-approved name change, etc.).
Yes ☐	**No** ☐	**4.** Has the owner, director/administrator, any staff, or affiliate as defined in the minimum standards ever had a license to operate any type of child care facility, residential home, maternity home, or child placing agency denied, revoked, suspended, or not renewed? If your answer is "Yes", please provide the name of the person, person's position at the time of denial/revocation/suspension/nonrenewal and person's current position, the name of the facility or agency, the date of the license denial, revocation, suspension, or non-renewal, the type of adverse action involved (e.g., license denial, license revocation, license suspension, license not renewed), the name of the regulatory agency or court taking the adverse action, the city and state where the regulatory agency or court is located, and the reasons given by that agency/court for its action.
Yes ☐	**No** ☐	**5.** Has the owner, director/administrator, or any staff ever been denied approval, or had approval denied, revoked, suspended, or not renewed, to serve as a foster or adoptive parent? If your answer is "Yes", please provide the name of the person, person's position, the date of the denial, revocation, suspension, or non-renewal, the type of adverse action involved (approval/licensure to serve as foster or adoptive parent denied, approval/licensure revoked, approval/licensure suspended, approval/licensure not renewed), the name of the regulatory or court taking the adverse action, the city and state where the regulatory agency or court is located, and the reasons given by that agency/court for its action.
Yes ☐	**No** ☐	**6.** Has the owner, director/administrator, or any staff ever been the subject of a validated complaint of abuse, neglect, and/or exploitation of any elderly or infirm person? If your answer is "Yes", please provide the name of the person, person's position, and disposition of the case.
I certify that I have personally completed the Disclosure Form. I further certify that I have carefully investigated all facts necessary to complete the Disclosure Form, and that all information contained on this Disclosure Form is true and correct to the best of my knowledge and ability. I understand that knowingly providing false information on this Disclosure Form, may cause the application to be denied, license revoked or not renewed. I further understand that failure to provide complete information may result in the application being denied or my license revoked, or not renewed. I also understand that knowingly providing false information may result in criminal charges. I understand that failure to comply with the law and regulations governing the licensure of specialized programs could result in the application being denied or licensed revoked.		
Date:		
Signature of Owner or Director/Administrator:		
Type or Print Name and Title:		