



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Licensure and Regulatory Services

255 Rockville, Suite 100, 1st Floor, Rockville, MD 20850

Phone: 240-777-3986 / Fax 240-777-3088

www.montgomerycountymd.gov/licensure

Group Home License Application

Application is hereby made for a license to operate A Group Home in Montgomery County, MD (LICENSES ARE NOT TRANSFERABLE FROM LOCATION TO LOCATION OR PERSON TO PERSON)

TODAY'S DATE: _____

NEW* Use & Occupancy Certificate for New or Change of Ownership facilities, must be provided with applications, if 9 or more occupants reside on the premise.

RENEWAL OWNERSHIP CHANGE CHANGE IN NUMBER OF OCCUPANTS

FACILITY NAME CHANGE: _____

GROUP HOME TYPE: ELDERLY / \$60 per bed NON-ELDERLY / \$50 per bed (select type below)

MINORS or CHRONIC MENTALLY ILL

NAME OF GROUP HOME: _____

ADDRESS: Street Number Street Name City State Zip Code

TELEPHONE NO.: FAX NO.:

Water Source: WSSC/City or Well Sewage Disposal: WSSC/City or Septic

NAME OF FACILITY CONTACT PERSON: EMAIL:

NAME OF OWNER OR CORPORATION: First and Last name of Owner or Corporation Name

ADDRESS: Street Number Street Name City, State, Zip Code

TELEPHONE NO.: FAX NO.: FEDERAL TAX ID NO.:

STAFF DIRECTOR OR EMERGENCY CONTACT NAME (FIRST AND LAST):

EMAIL ADDRESS ((STAFF DIRECTOR OR EMERGENCY CONTACT PERSON):

PLEASE COMPLETE EMERGENCY CONTACT INFORMATION SHEET (ENCLOSED)

OCCUPANTS WHO CLAIM RESIDENCE:

RESIDENTS (# of licensed beds) _____

NUMBER OF LIVE IN EMPLOYEES _____

OTHER (CHILDREN, FAMILY OR FRIENDS RESIDING ON THE PREMISES) _____

TOTAL number of All Occupants who claim residence: Number of rotating staff (non-Occupants):

State Agency which licenses the Group Home: _____

Annual renewal applications submitted after the license expiration date will be charged, a \$100 late fee, in addition to the renewal fee.

Signature: Title: _____

Printed Name: Date: _____

Submit completed application and fee to address above. CASH IS NOT ACCEPTED. Checks/Money Orders payable to "Montgomery County, Maryland". Fee Paid: _____

Payment Method: Check or Money Order Visa or Master Card Only (complete information below)

CREDIT CARD PAYMENT SECTION (confidential fax line for credit card payment: 240-777-4531)

Credit Cardholder's Name: Credit Card No: _____

Exp. Date: 3 Digit Security Code: Amount: \$ _____

I agree to pay the above total amount according to the card issuer agreement:

Cardholder's Signature: _____

OFFICE USE ONLY

Receipt No.: _____ Date Received: _____ Amount Paid: _____ Staff Initials: _____

Check/Money Order No.: _____ Credit Card Approval Code (MC/VISA): _____