HEALTH DEPARTMENT
ENVIRONMENTAL HEALTH DIVISION
Lena H. Jones, MPA · Health Director

Parcel Id #: _____

Permit #: _____

Request for Evaluation of a
Residential Care Facility

1. Facility Name: _____
   Facility Address: _____ Unit (where applicable): _____
   City: _____ Zip: _____
   License Number_____ (if applicable) **Maximum Capacity**: _____

2. Contact Person Information:
   Name: _____ Phone (day): _____
   Phone (cell): _____ Fax: _____
   Email Address: _____

3. Supervising Agency (if applicable): _____
   Agency Address: _____City: _____Zip:_____
   Supervising Agency contact number: _____

4. Owner of Facility: _____

5. Type of License: ☐Adult Care Home, ☐Family Care Home, ☐Mental Health, ☐Maternity Home, ☐Other _____

6. This request is for a: ☐ New facility ☐ Facility re-licensing

7. What dates/times someone will be onsite at the facility? _____

8. **Sewage Disposal**: ☐Municipal (City/County Sewer) ☐Septic system

9. **Water Supply**: ☐Municipal (City/County Water Supply) ☐*Private well (*water sampling required)

10. Comments: _____

Signature of Applicant: _____ Date_____
Name of Applicant (PRINT):_____
Applicant Phone Number: _____

***Once this Department receives this application, an inspector will either 1) Call and schedule an inspection or 2) Conduct an unannounced inspection.*