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J-800-2960
Revised June 2014



BY: _____
APPLICATION FOR A LICENSE TO OPERATE A RESIDENTIAL CHILD-CARE FACILITY

CHILD CARE LICENSING

Purpose: Use this form to apply for a license to operate a residential child-care facility, including a child-placing agency.

Directions: After completing this form, please mail it and any other materials requested to your nearest DFPS Licensing office. For information on local Licensing offices, see:

http://www.dfps.state.tx.us/Child_Care/Local_Child_Care_Licensing_Offices/default.asp

PART I – ABOUT YOUR OPERATION

Name of Operation South Texas Family Residential Center					Telephone Number 830-678-6500	
Street Number 300	Street Address El Rancho Way	Apartment Number	City Dilley	County Frio	State Texas	Zip Code 78017
Type of Governing Body:						
<input type="checkbox"/> Sole Proprietorship			<input type="checkbox"/> Nonprofit Corporation			
<input type="checkbox"/> Partnership			<input type="checkbox"/> Political Subdivision			
<input type="checkbox"/> Limited Partnership			<input type="checkbox"/> Nonprofit Corporation with Religious Affiliation			
<input type="checkbox"/> Limited Liability Partnership			<input type="checkbox"/> Nonprofit Association with Religious Affiliation			
<input type="checkbox"/> Association			<input type="checkbox"/> Limited Liability Company			
<input checked="" type="checkbox"/> Corporation			<input type="checkbox"/> State Operated			
<input type="checkbox"/> Nonprofit Association						

PART II – APPLICANT INFORMATION

Section 1

Complete this section if your type of governing body is: SOLE PROPRIETORSHIP OR PARTNERSHIP (General, Limited Partnership, Limited Liability Partnership)

If you have more than two partners, attach the information requested here for each.

Name of Entity (Required for a Limited Partnership or Limited Liability Partnership)			Name of Sole Proprietor or Partner		Telephone Number	
Street Number	Street Address or P.O. Box	Apartment Number	City	County	State	Zip Code
Name of Second Partner			Telephone Number			
Street Number	Street Address or P.O. Box	Apartment Number	City	County	State	Zip Code
<input type="checkbox"/> Check here, if you are (or a partner is) a military service member, military spouse, or military veteran. (Applies only if your governing body is a sole proprietorship or partnership.)						

Section 2

Complete this section, if your type of governing body is: association, corporation, limited liability company, nonprofit corporation, nonprofit association, political subdivision, nonprofit corporation with religious affiliation, nonprofit

PART II – APPLICANT INFORMATION

association with religious affiliation, or state operated						
Name of Organization or Governing Body Corrections Corporation of America				Telephone Number 800-624-2931		
Street Number 10	Street Address or P.O. Box Burton Hills Blvd	Apartment Number	City Nashville	County Davidson	State TN	Zip Code 37215

PART III – CHILD POPULATION

<input checked="" type="checkbox"/> Boys	<input checked="" type="checkbox"/> Girls	Age Range: 2 to 17	Expected Number of Children: 600
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PART IV – OPERATION TYPE AND SERVICES

OPERATION TYPE (Select one type of operation.)	PROGRAMMATIC SERVICES (Select all that apply for your type of operation.)	TREATMENT SERVICES (Select all that apply for your type of operation.)
<input type="checkbox"/> General Residential Operation operating as a Residential Treatment Center	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Emergency Care Services <input type="checkbox"/> Respite Child Care <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services <input type="checkbox"/> Therapeutic Camp Services	<input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs
<input checked="" type="checkbox"/> General Residential Operation offering emergency care services ONLY	<input checked="" type="checkbox"/> Child-Care Services <input checked="" type="checkbox"/> Emergency Care Services <input type="checkbox"/> Respite Child Care <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services	<i>(Select one of the following treatment services only if your emergency care services program is limited to a specific target population.)</i> <input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs
<input type="checkbox"/> General Residential Operation offering Child Care Services ONLY	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Transitional Living Program	<i>(Treatment services are not permitted for operations that provide child care services only)</i>
<input type="checkbox"/> General Residential Operation offering multiple services	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Emergency Care Services <input type="checkbox"/> Respite Child Care <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services <input type="checkbox"/> Therapeutic Camp Services	<input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs
<input type="checkbox"/> Child-Placing Agency <input type="checkbox"/> Foster Care <input type="checkbox"/> Adoption	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services <input type="checkbox"/> Respite Child-Care Services	<input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs

PART IV – OPERATION TYPE AND SERVICES

<input type="checkbox"/> Independent Foster Family Home	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services <input type="checkbox"/> Respite Child-Care Services	<input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs
<input type="checkbox"/> Independent Foster Group Home	<input type="checkbox"/> Child-Care Services <input type="checkbox"/> Transitional Living Program <input type="checkbox"/> Assessment Services <input type="checkbox"/> Respite Child-Care Services	<input type="checkbox"/> Emotional Disorders <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Pervasive Development Disorder <input type="checkbox"/> Primary Medical Needs

PART V – PERMIT HISTORY

Do you (the applicant) have either a permit to provide any other type of child-care or child-placing services or a pending application to provide such services? Yes No

If yes, specify the name of the operation and type of permit: Licensed Temporary Shelter Program

Have you (the applicant) ever been denied a permit to provide child-care or child-placing services?
 Yes No

If yes, provide the date of denial: _____ Type of operation denied _____

Operation's address (Street, City, State, and Zip Code):
 300 El Rancho Way Dilley, TX 78017 County
 Frio

What was the reason for the denial?

Have you (the applicant) ever had a permit for child-care or child-placing services revoked?
 Yes No

If yes, provide date of the revocation: _____ Type of operation revoked _____

Operation's address (Street, City, State, and Zip Code): _____ County _____

If the revocation occurred in another state, list the name and address of the regulatory body that issued the revocation:

What was the reason for the revocation?

Have you (the applicant) ever been prohibited or barred from operating a child-placing agency or any other type of child-care operation? Yes No

If yes, provide the date of the prohibition or bar: _____ Type of operation barred? _____

Operation's address (Street, City, State, and Zip Code): _____ County _____

If the bar occurred in another state, list the name and address of the regulatory body that issued the bar:

PART V – PERMIT HISTORY

What was the reason for the prohibition or bar?		
Have you (the applicant) ever been a controlling person at a residential operation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, provide the dates:	Was the operation's permit revoked? If so, provide the date of revocation:	Name of the operation:
Operation's address (Street, City, State, and Zip Code):		County

PART VI – ADDITIONAL INFORMATION FOR PUBLICATION ON THE DFPS WEBSITE

Website Address: http://	<u>http://www.cca.com/facilities/south-texas-family-residential-center</u>		
Email Address:	<u>Janice.Killian@CCA.com</u>		
Name of Administrator or Executive Director:	<u>Janice Killian</u>		
Behavior Interventions: (Check all that apply)			
<input checked="" type="checkbox"/> Personal Restraints	<input type="checkbox"/> Seclusion	<input type="checkbox"/> Mechanical Restraints	<input type="checkbox"/> Emergency Medication
Devices: (Check all that apply)			
<input type="checkbox"/> Protective Devices	<input type="checkbox"/> Supportive Devices		
Special Services Provided: (Check all that apply)			
<input type="checkbox"/> Young-Adult Care	<input type="checkbox"/> Interstate Compact on the Placement of Children (for children from another state)		
<input type="checkbox"/> International Adoptions	<input type="checkbox"/> Physically Challenged (provides accommodations for children with physical disabilities)		
<input type="checkbox"/> Human Trafficking Services			

PART VII – FOR CHILD-PLACING AGENCIES

Attach a complete list of your offices and agency homes, and indicate which of your offices regulates each home.
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PART VIII – DESIGNATING A GOVERNING BODY

Name of Chief Executive Officer or Head of the Governing Body: Janice Killian				Telephone Number (000-000-0000): 512-529-2419	
Mailing Address: 1011 Creston Cove	City: Hutto	County: Williamson	State: TX	Zip Code: 78634	
Name of Designated Governing Body: CCA SOTEX				Telephone Number (000-000-0000): 830-678-6500	
Mailing Address: 300 El Rancho Way	City: Dilley	County: Frio	State: TX	Zip Code: 78017	

I hereby designate the person stated above as the official representative (designee) to speak for and act on our organization's behalf.

- I understand that, as the permit holder, the governing body is ultimately responsible for maintaining compliance with the minimum standards and other child care licensing law.
- I understand that all waivers and variances must be requested and signed by me or by the designee.
- I understand that the governing body must notify the DFPS Licensing division anytime there is a change in the governing body's designee.
- I understand that the DFPS Licensing division provides the governing body and all controlling persons in the operation with documents showing the operation's compliance or deficiencies and any remedial actions that Licensing takes against the operation.

AUTHORIZING SIGNATURE

Signature of the Chief Executive Officer or Head of the Governing Body or Each Partner: X <i>Jamie Kelli</i>	Signer's Title: Facility Administrator	Date Signed: September 1, 2015
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PART IX – FOR INDEPENDENT FOSTER HOMES

Licensing will conduct a background check, including a criminal history check, on applicants for a license to operate an independent foster home.

Some criminal convictions:

- preclude an applicant from operating a licensed foster home; and
- may also be considered in evaluating the application.

See 40 TAC Chapter 745, Subchapter F, for Licensing's rules on background checks, including those that would impact the approval of an application.

PART X – CERTIFICATION AND SIGNATURE

I certify that the information provided here contains no willful misrepresentation or falsification and that it is true and complete to the best of my knowledge and belief. I understand that any willful misrepresentation is cause for immediate denial of the application or later denial or revocation of the license. The documentation to complete this application is attached (see the checklist provided below). I understand that this application will be returned if the attached documentation is incomplete or does not conform to applicable laws. If a license is granted, there will be no racial discrimination in the admission or care of children.

Signature of Applicant, Designee, or Head of the Governing Body X <i>Jamie Kelli</i>	Date Signed: September 1, 2015
<input checked="" type="checkbox"/> Floor plan of the building and surrounding space to be used (with indoor dimensions and the purpose of all rooms provided. I if applicable, specify where the children and caregivers will sleep)	<input checked="" type="checkbox"/> Proof of liability insurance (or documentation that you are unable to obtain liability insurance) and a copy of the notice to parents about whether you have liability insurance.

PART X – CERTIFICATION AND SIGNATURE

<input checked="" type="checkbox"/> Proof that the for-profit corporation or the limited liability company is not delinquent in paying franchise tax.	<input checked="" type="checkbox"/> Policies, procedures, and documentation, as required by either form 2784, 2785, or 2786 (if applicable)
<input checked="" type="checkbox"/> Verification of Fee Payment (if applicable)	<input checked="" type="checkbox"/> Request for Criminal History and Central Registry Check
<input checked="" type="checkbox"/> Personal History Statement (if applicable)	<input checked="" type="checkbox"/> Controlling Person Form

DRIVING DIRECTIONS TO THE OPERATION: (Please provide clear and concise directions for driving to your operation from the nearest DFPS Licensing office)

Family & Protective Services Department
3635 Southeast Military Drive, San Antonio, TX 78223

Get on I-37 S
2 min (0.7 mi)

Head west on SE Military Dr toward Glasgow Dr
0.2 mi

Use the left lane to turn sharply right to stay on SE Military Dr
0.1 mi

Use the left 2 lanes to turn left to merge onto I-37 S
0.4 mi

Follow I-410 W and I-35 S to I-35 Frontage Rd in Dilley. Take exit 84 from I-35 S
1 h 4 min (73.9 mi)

Merge onto I-37 S
1.1 mi

Take exit 133 to merge onto I-410 W/US-281 S
Continue to follow I-410 W
11.7 mi

Take exit 53 toward Laredo
0.6 mi

Keep left at the fork and merge onto I-35 S
60.4 mi

Take exit 84 toward TX-85/Carrizo Springs
0.2 mi
Drive to TX-85 W
2 min (1.0 mi)

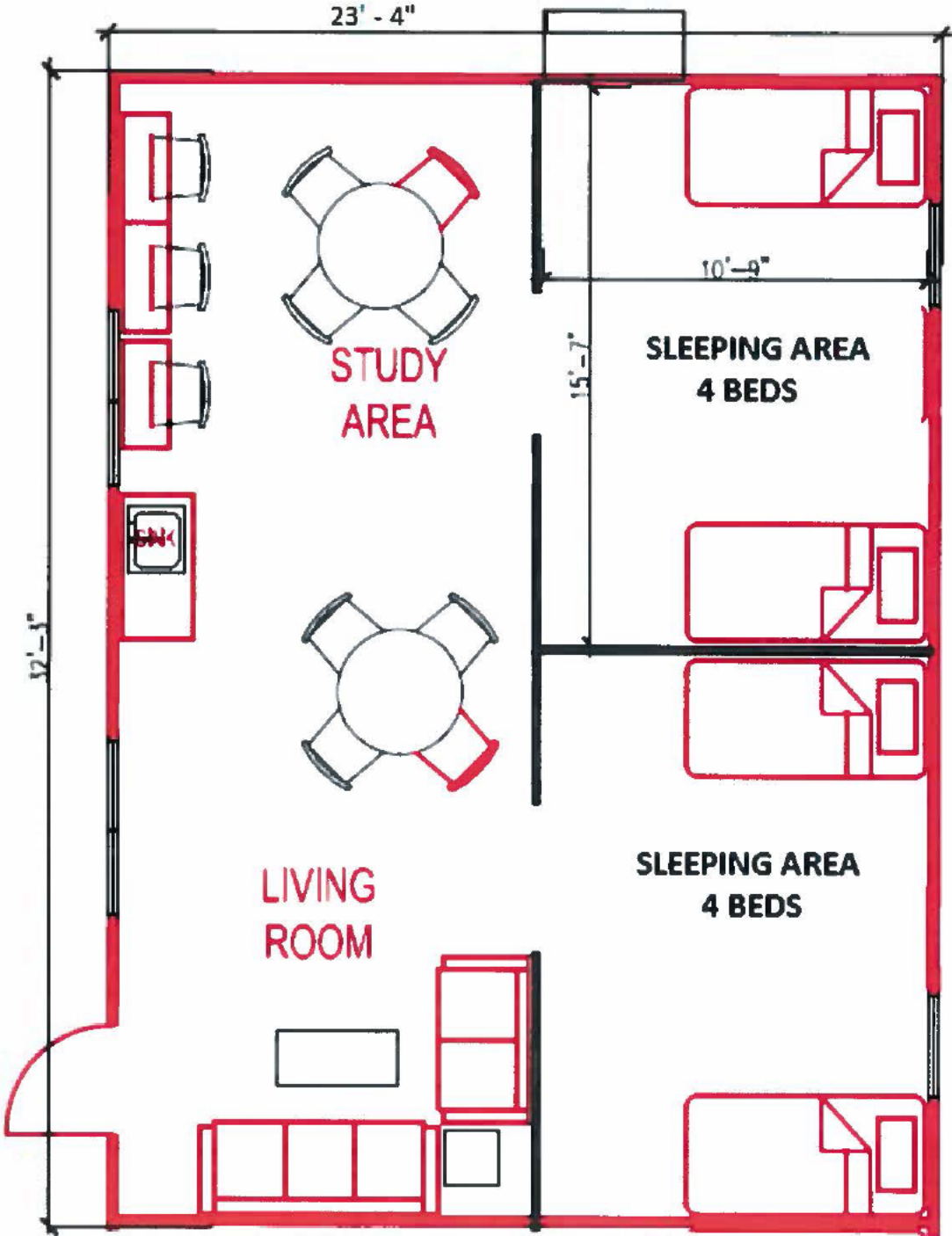
Merge onto I-35 Frontage Rd
0.2 mi

Turn right onto TX-85 W
0.8 mi
1503-1927 Texas 85
Dilley, TX 78017

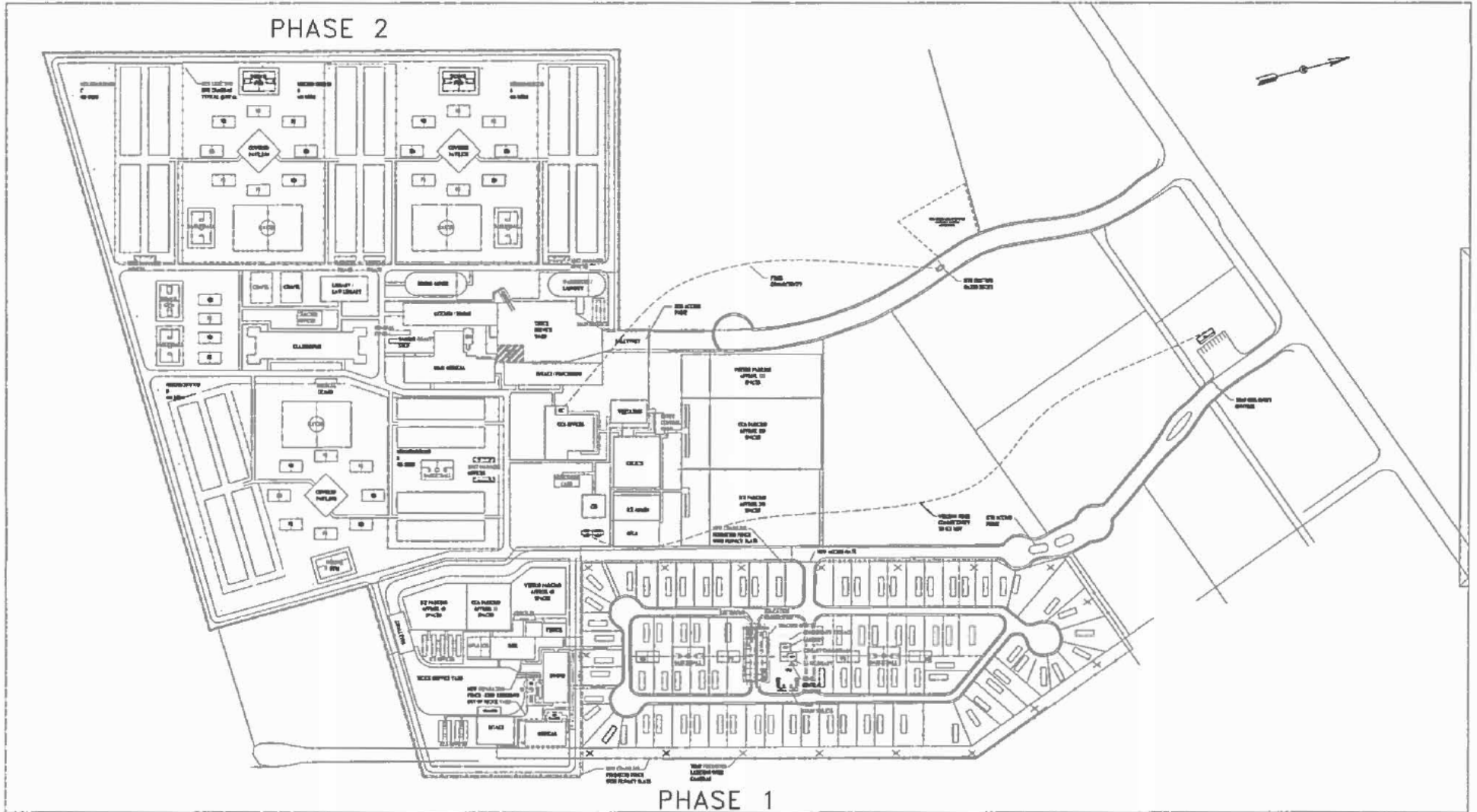
PRIVACY STATEMENT

DFPS values your privacy. For more information, read our privacy policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.

HOUSING ROOM



PHASE 2



PHASE 1

SEPTEMBER 12, 2014

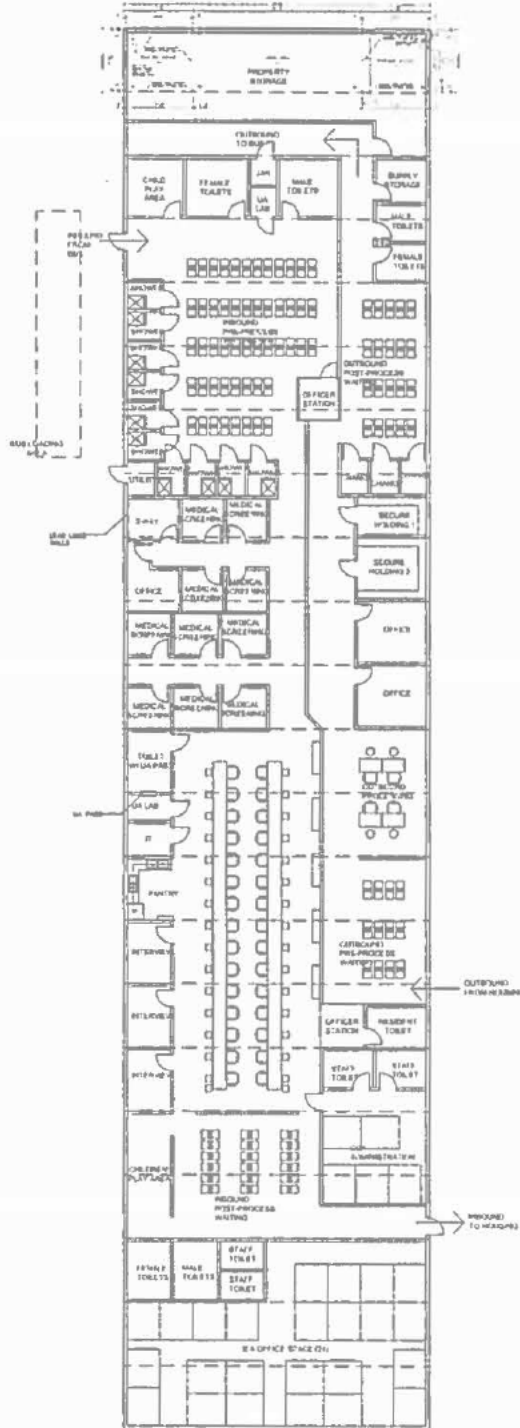
PROPOSED SOLUTION - PHASE 1 & 2
FOR THE SOUTH TEXAS FAMILY RESIDENTIAL
CENTER AT DILLEY, TEXAS

SOUTH TEXAS FAMILY RESIDENTIAL CENTER

TOTAL SITE AREA = +/- 50 ACRES



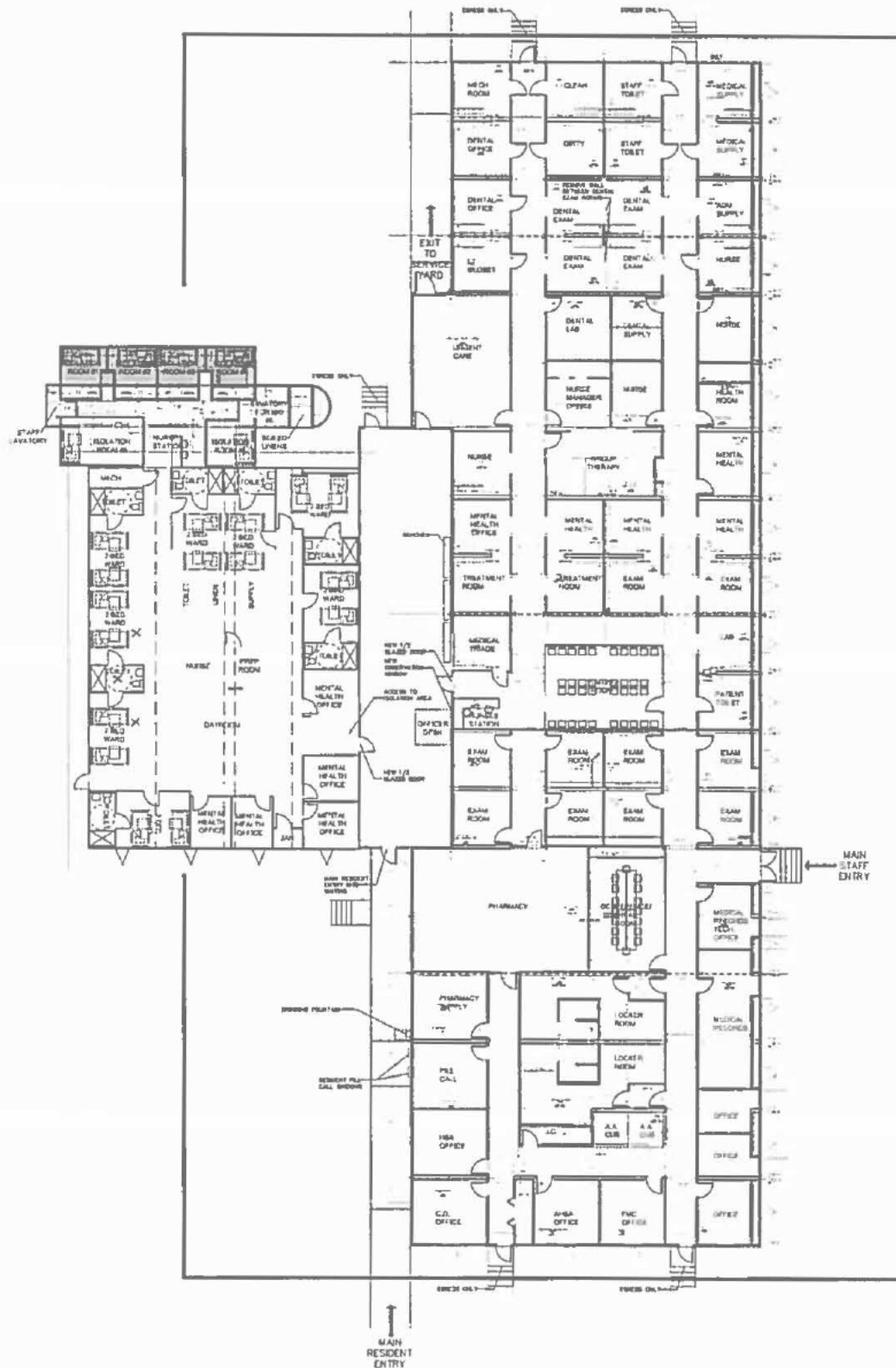
INTAKE/PROCESSING



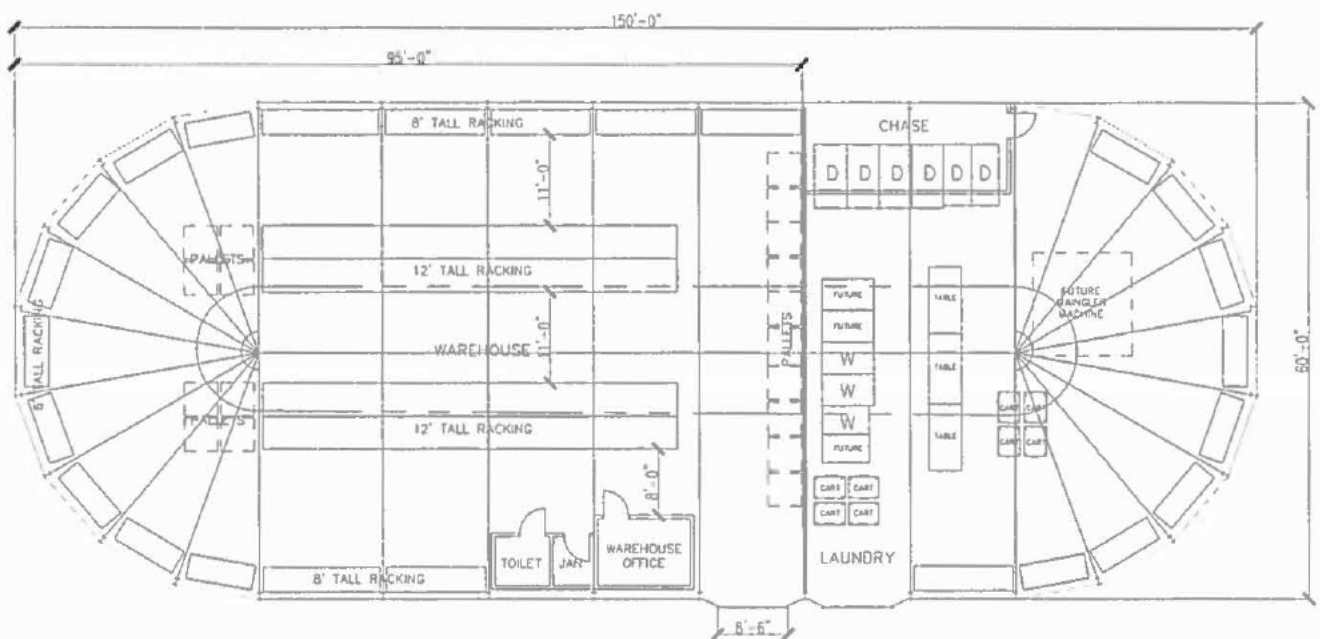
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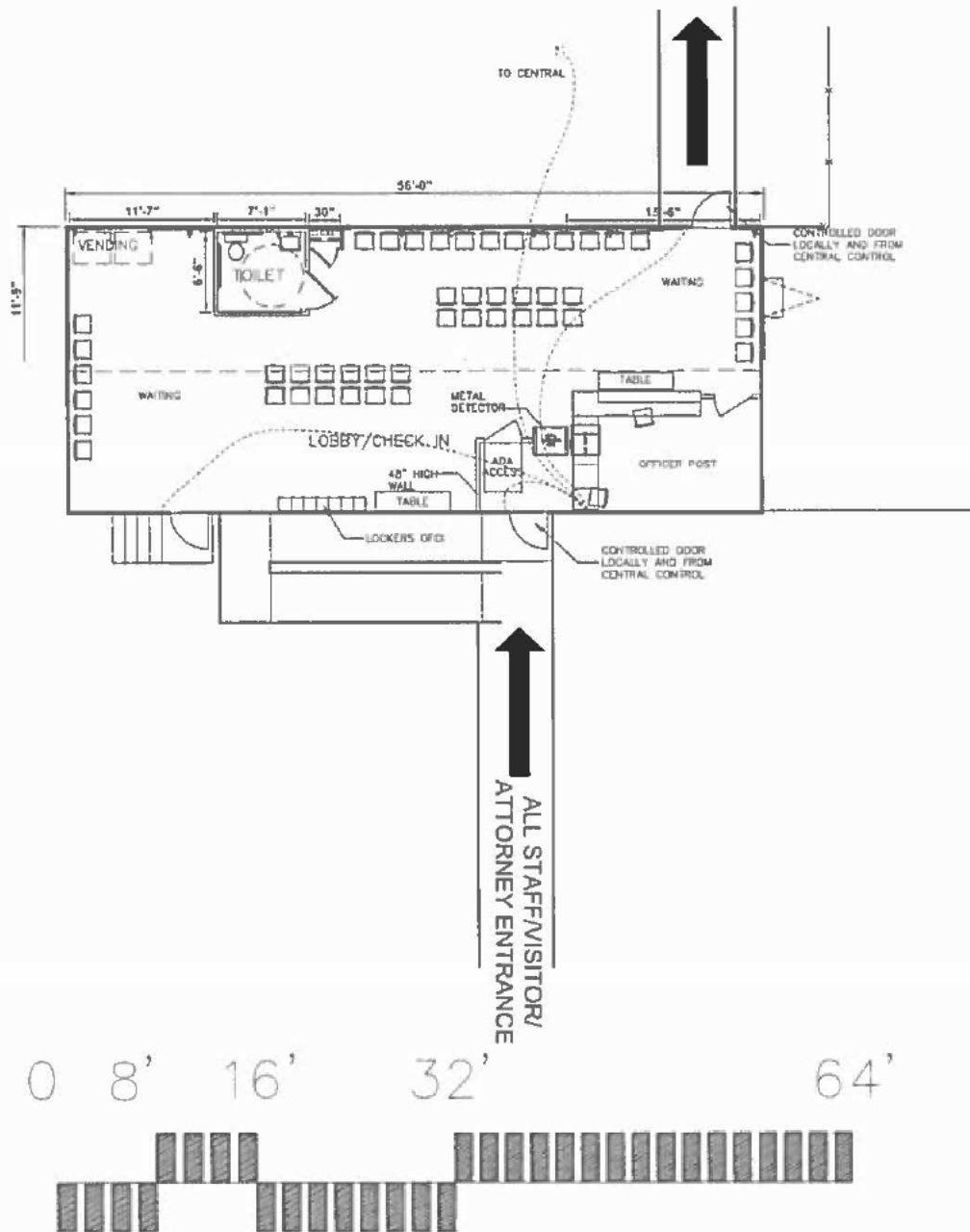
MAIN MEDICAL/ ISOLATION



WAREHOUSE/LAUNDRY



PHASE II LOBBY/CHECK IN



VISITATION

5.6K SF.



Page 8

MAIN LOBBY

Page 9

EOIR COURTS



Page 11

MONITORED CARE

CIS

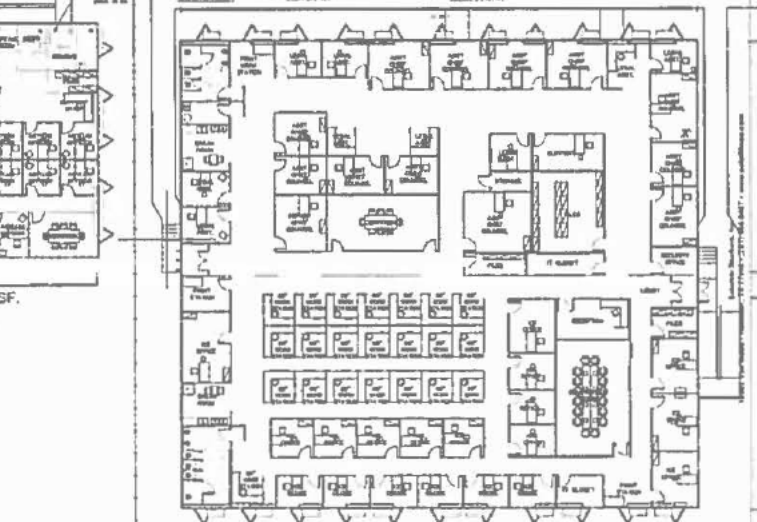
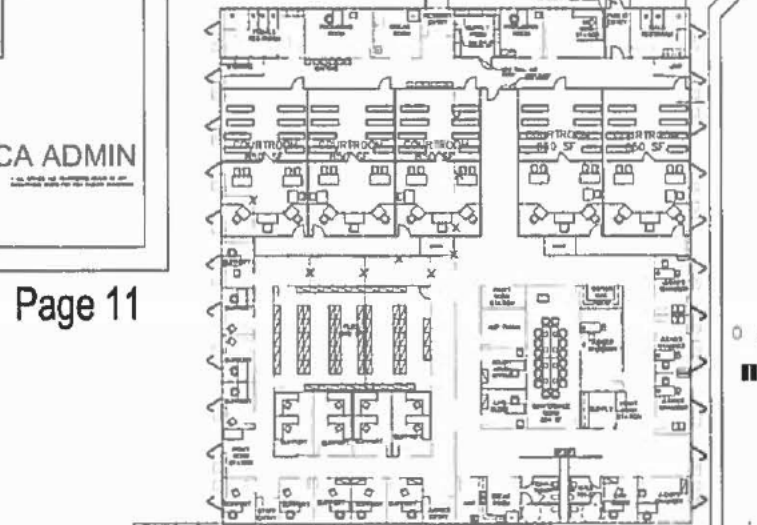
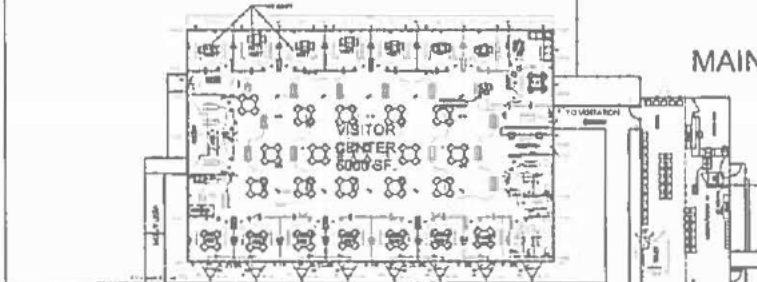
CIS 3600 SF.

Page 10

OPLA 7000 SF.

ICE ADMIN. 7800 SF.

ICE ADMIN/OPLA



ALL REVISIONS TO LOBBY LAYOUT WITHIN 10' RED LINE

ALL ICE STAFF ENTRANCE

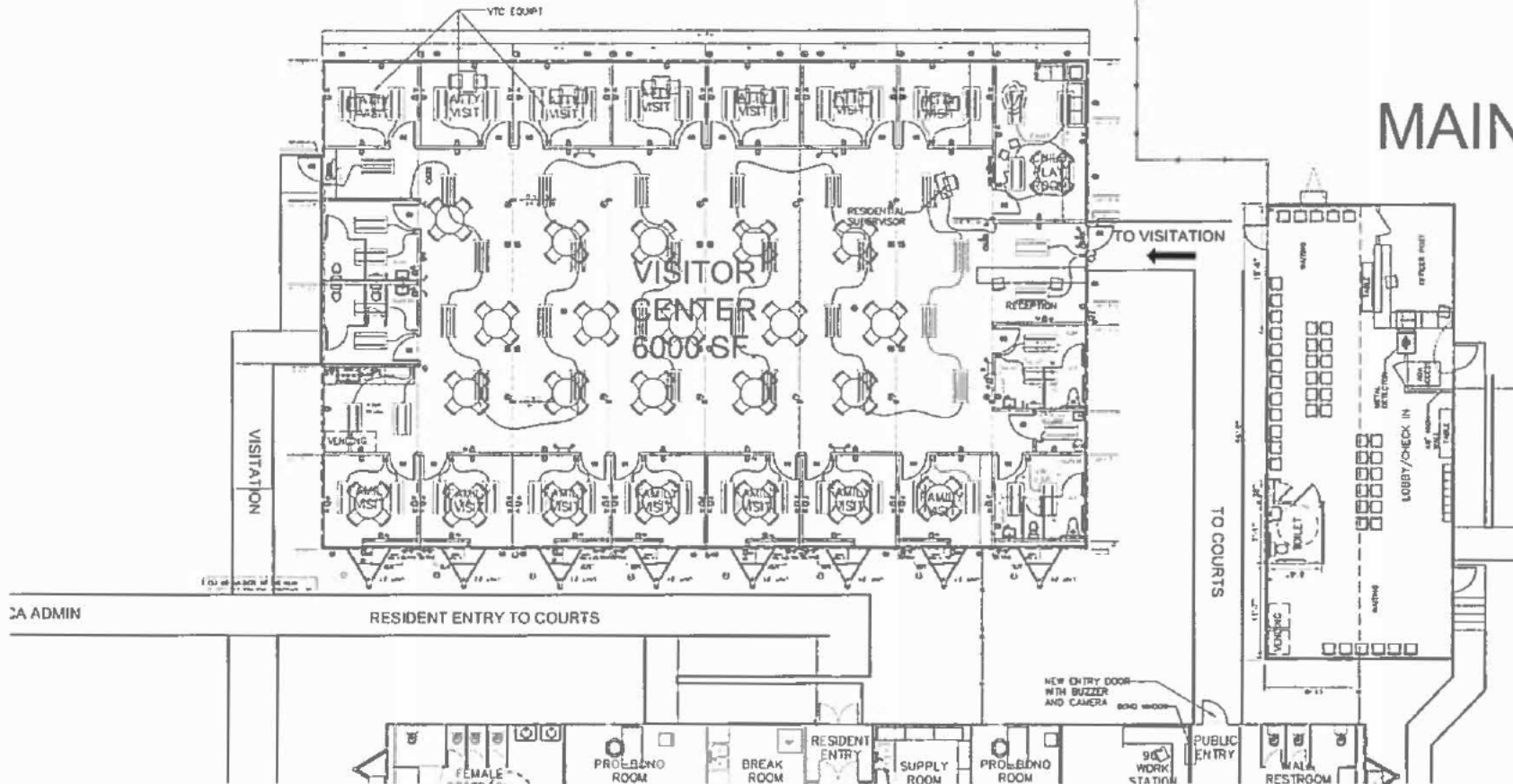
THIS PROJECT WAS A CONSULTING SERVICE PROVIDED BY LSC ARCHITECTS, P.C. FOR THE U.S. DEPARTMENT OF JUSTICE, ICE. THE ARCHITECTS ASSUME NO LIABILITY FOR THE ACCURACY OF THE INFORMATION PROVIDED HEREIN.

VISITATION

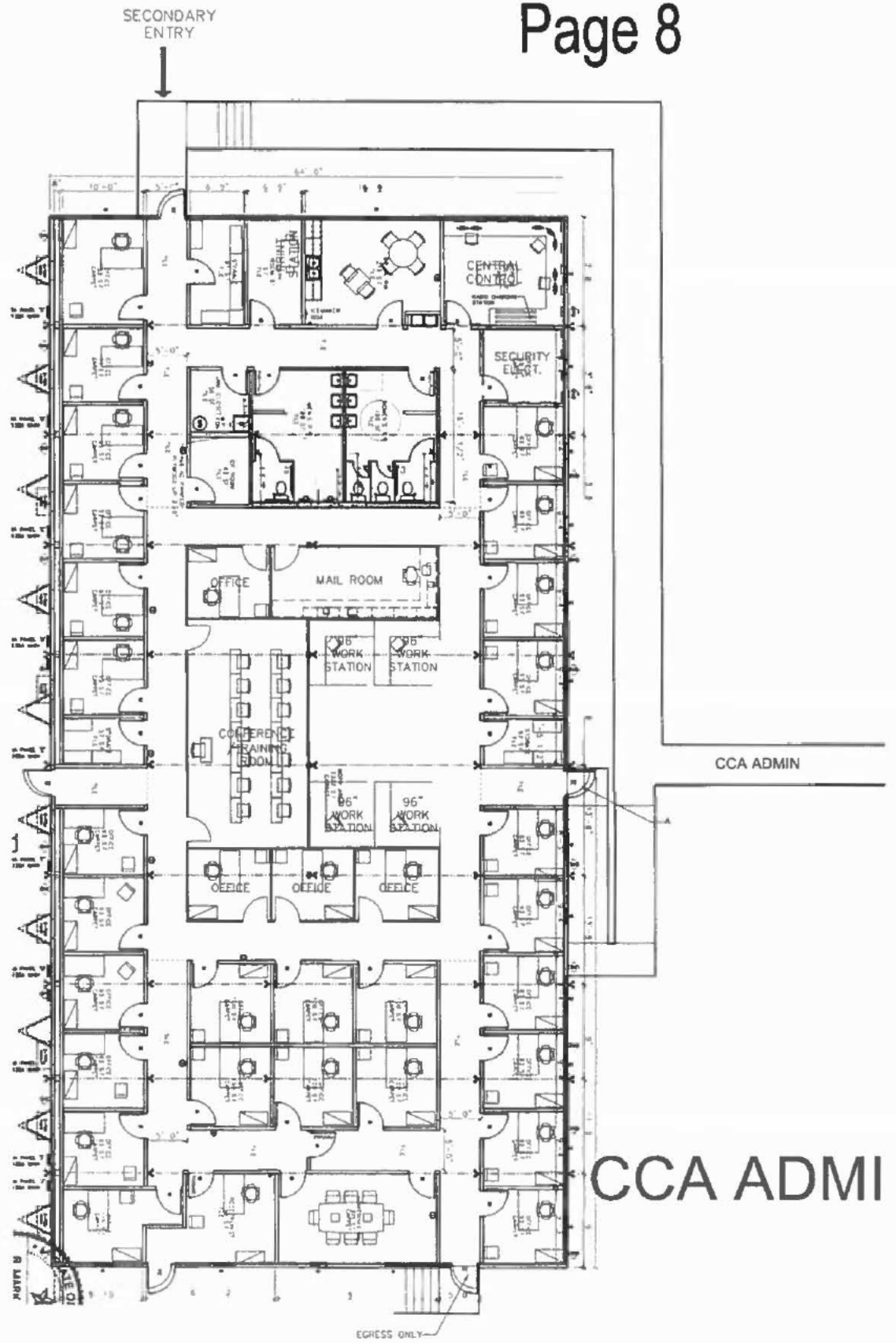
* NEED CHANGING TABLE IN RESTROOM TYPICAL ALL RESTROOMS

5.6K SF.

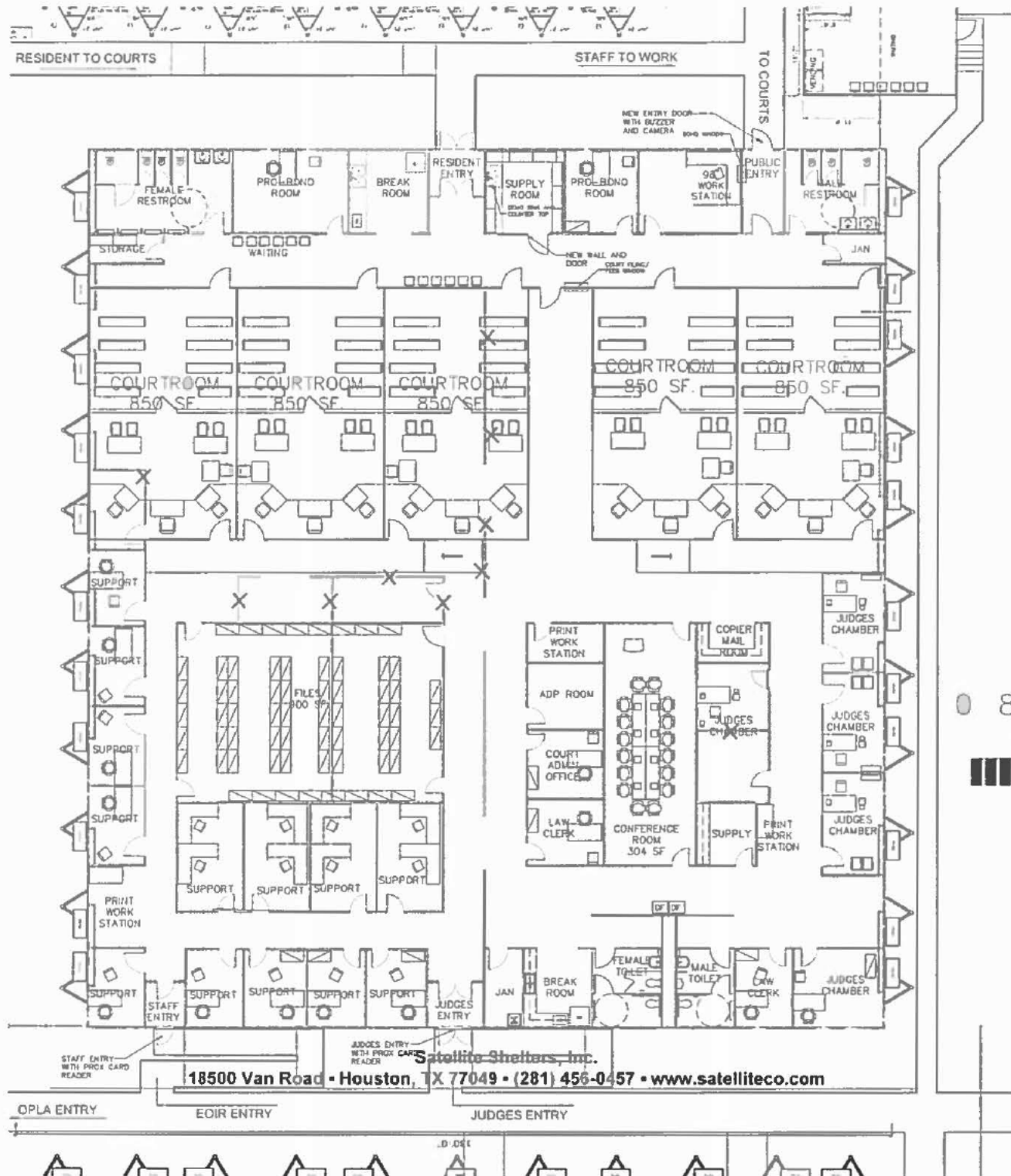
0 8' 16' 32' 64'



MAIN LOBBY



ALL RESIDENTS TO COURTS/CIS/VISITATION/MONITORED CARE →



Page 9

EOIR COURTS

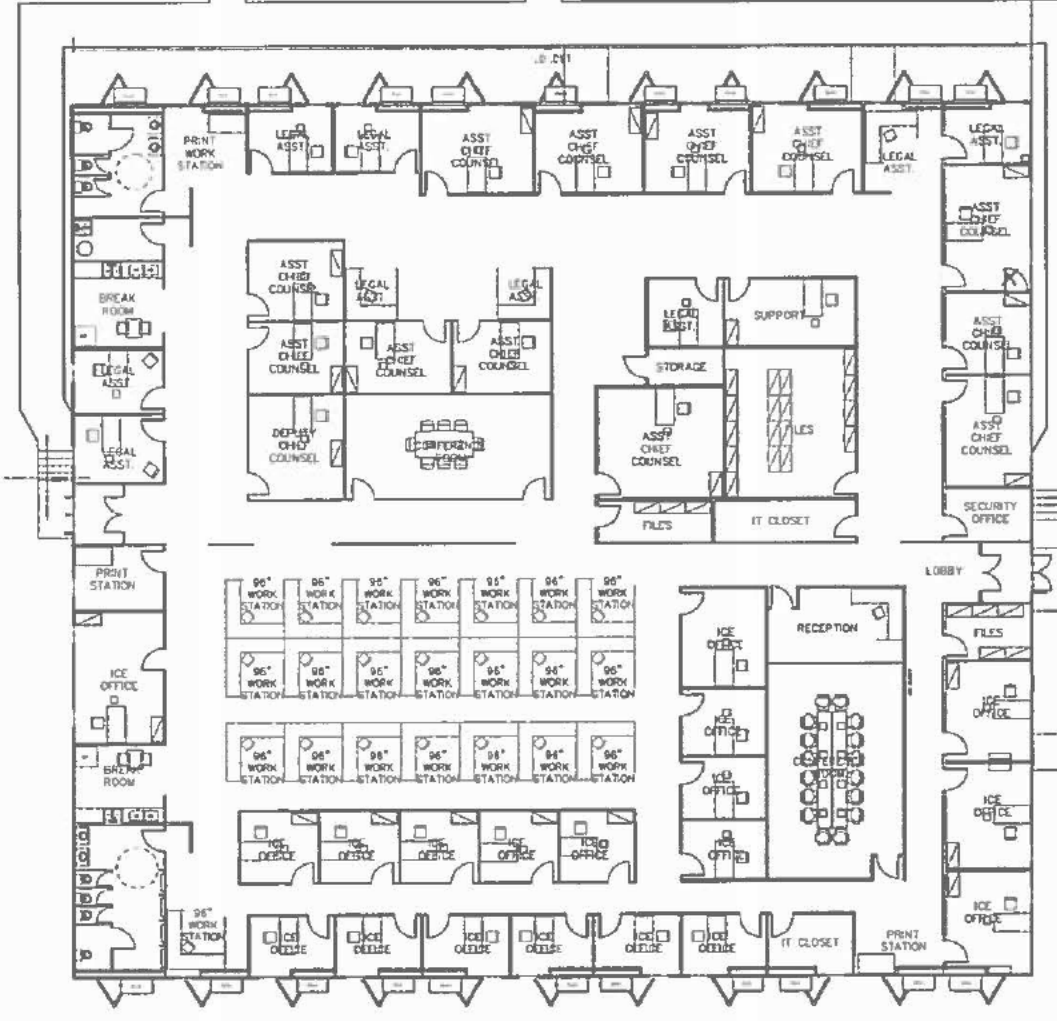
* NEED CHANGING TABLE IN RESTROOM TYPICAL ALL RESTROOMS



18500 Van Road • Houston, TX 77049 • (281) 456-0457 • www.satelliteco.com

Satellite Shelters, Inc.

ALL ICE STAFF ENTRANCE



OPLA 7800 SF.

ICE ADMIN. 7800 SF.

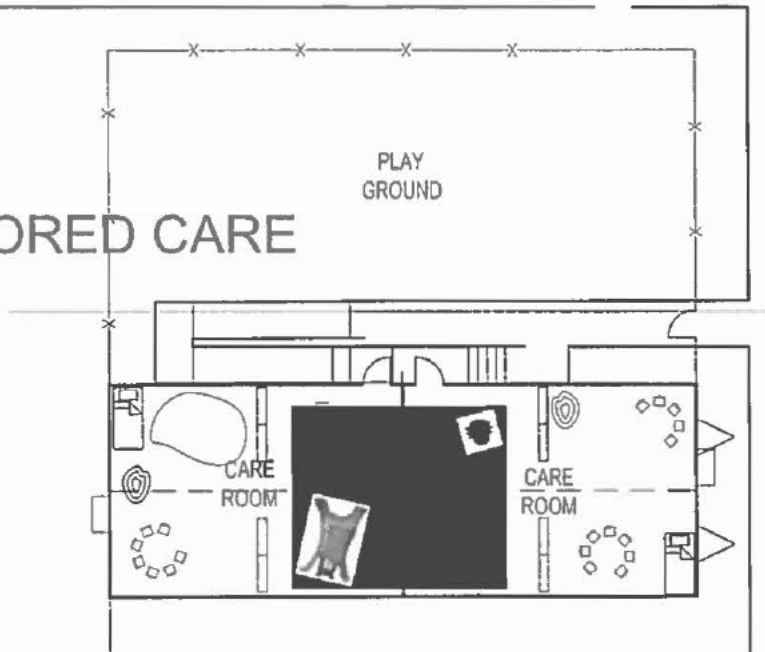
* NEED DINING TABLE IN RESTROOM TYPICAL ALL RESTROOMS
 ** ALL OFFICES AND CONFERENCE ROOMS TO GET DATA/PHONE CORDS PER ICE CABLING STANDARDS

ICE ADMIN/ OPLA

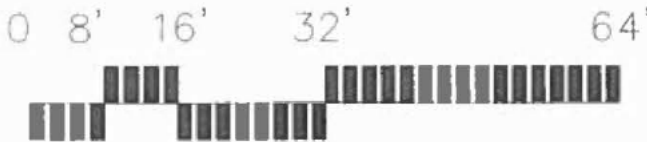
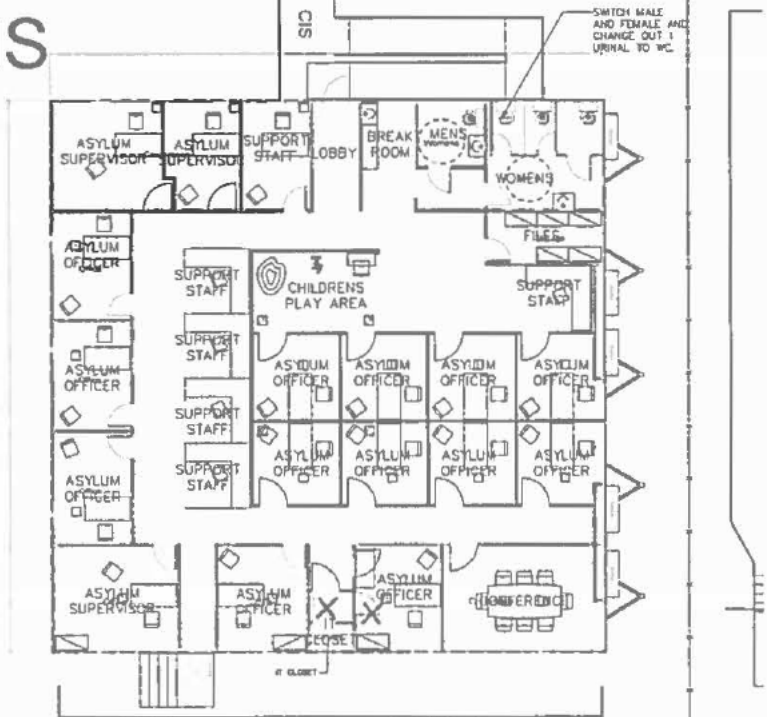


ALL RESIDENTS TO COURTS/CIS/VISITATION/MONITORED CARE →

MONITORED CARE



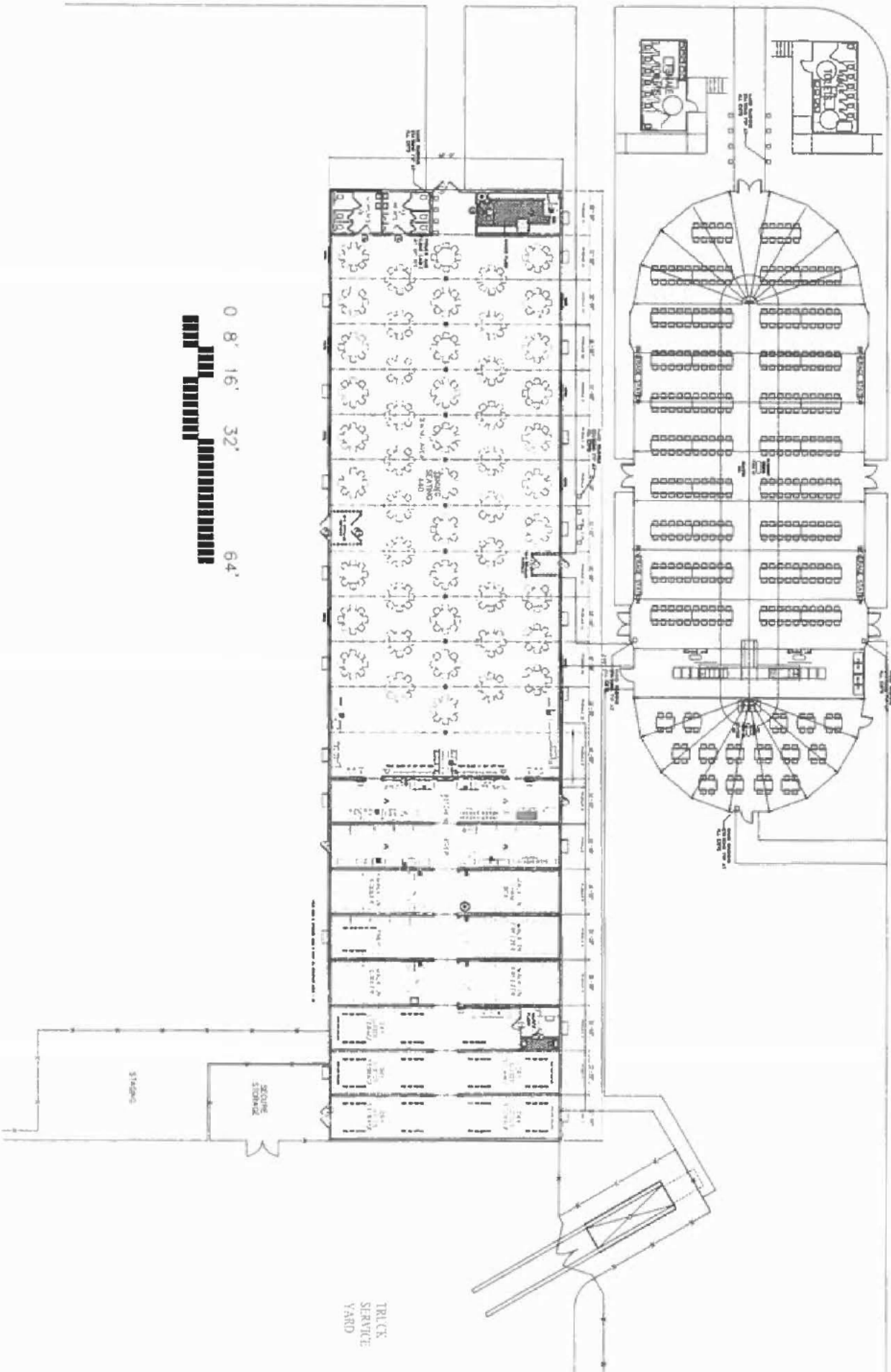
CIS



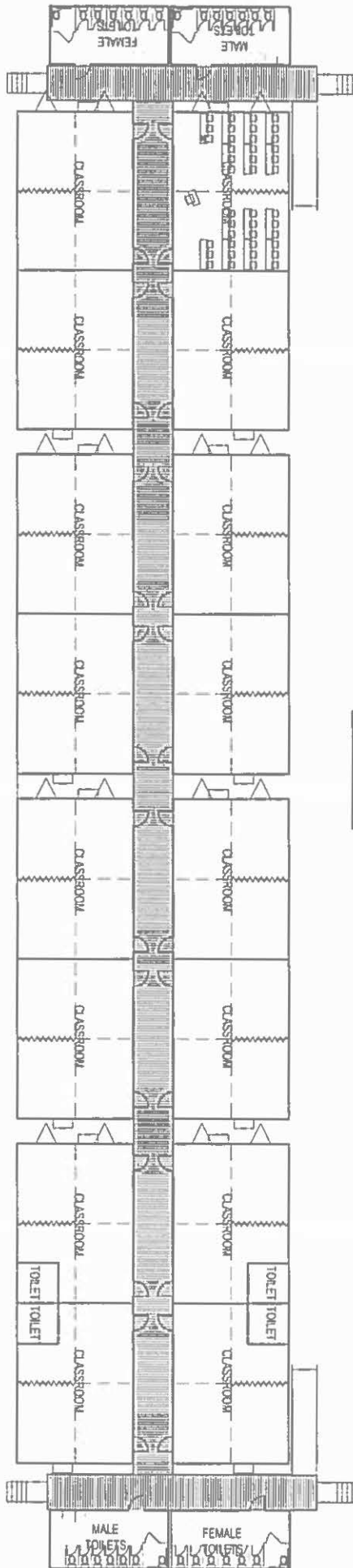
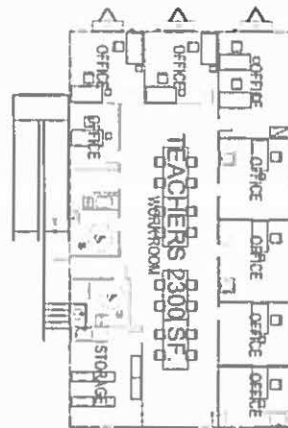
CIS 3600 SF.

* NEED CHANGING TABLE IN RESTROOM TYPICAL ALL RESTROOMS
* ALL OFFICES AND CONFERENCE ROOMS TO GET DATA/PHONE DROPS PER ICE CABLING STANDARDS

KITCHEN AND DINING



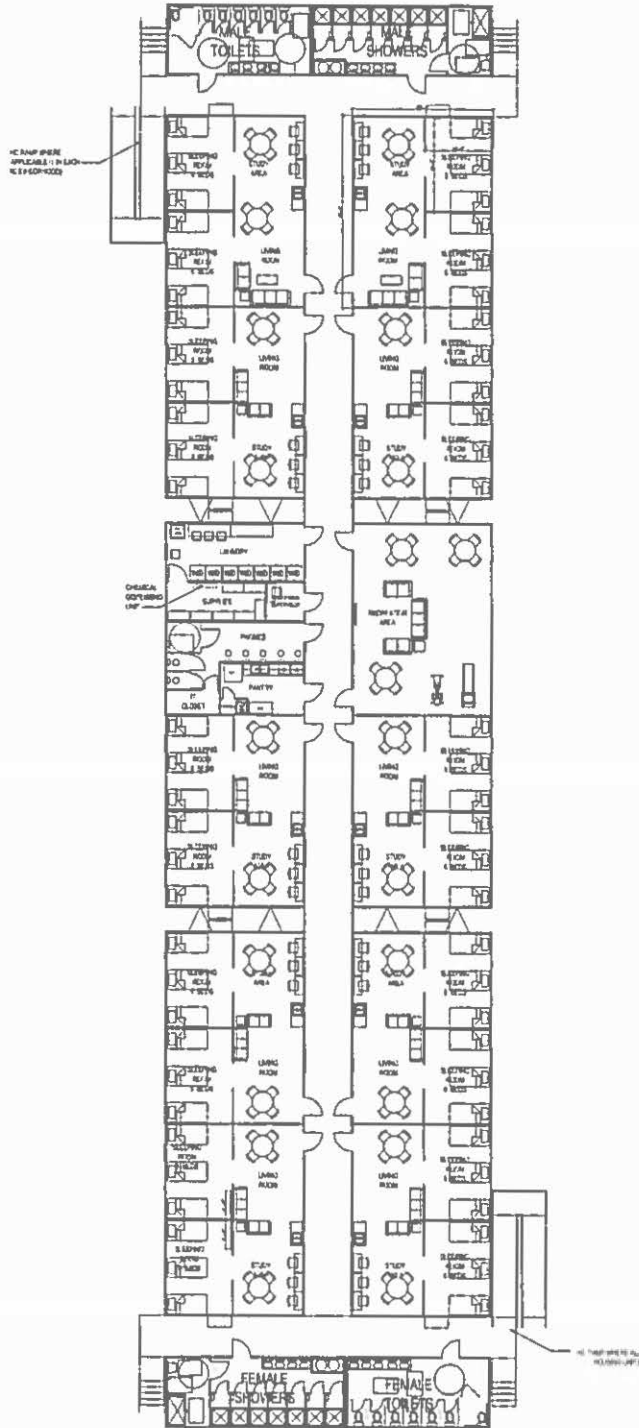
TEACHER OFFICES



EDUCATION



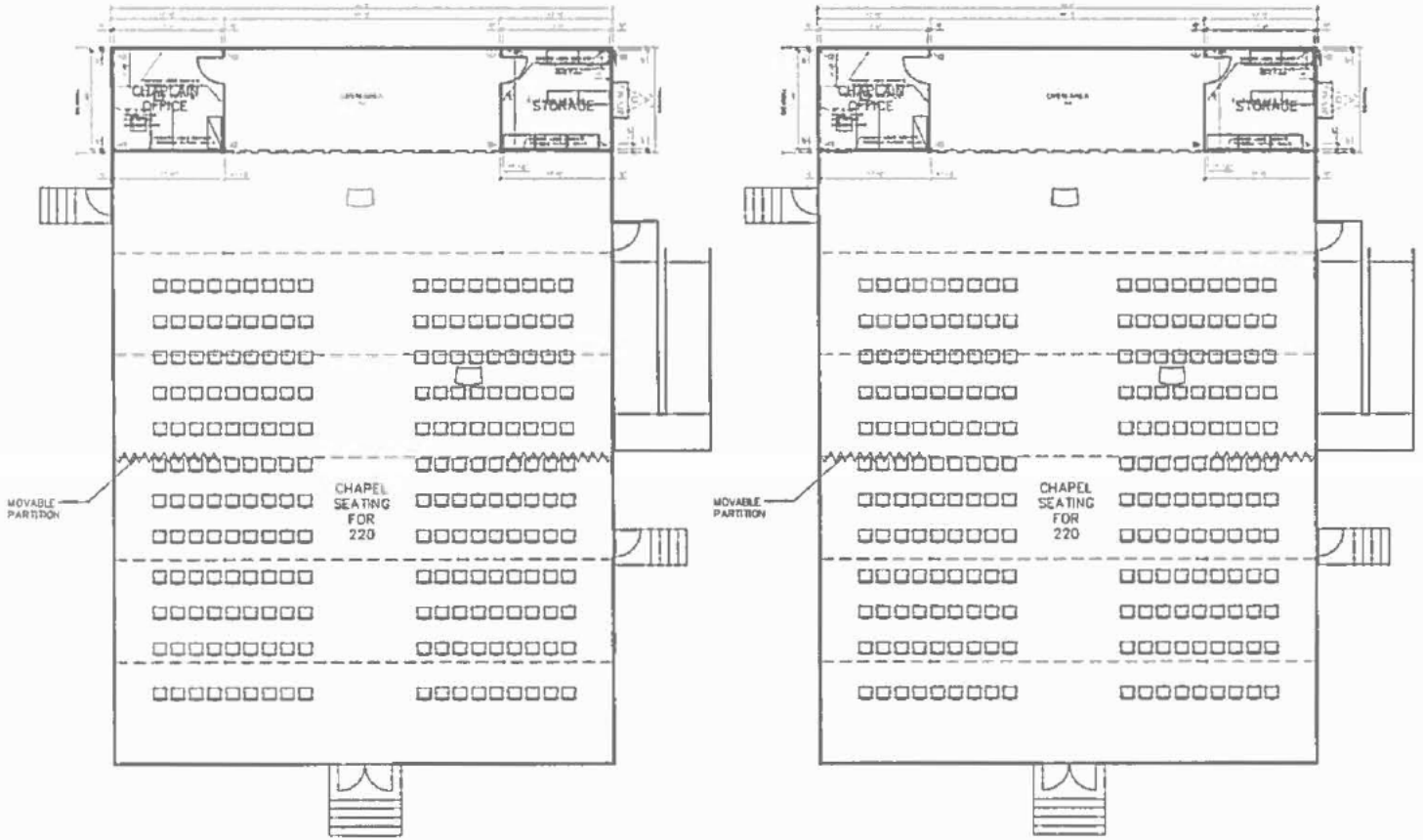
120 BED HOUSING



- * ALL SLEEPERS IN REACH OF CHILDREN SHALL BE GUARDED AND MARKED WITH SLEEPERS.
- * PROVIDE PRIORITY OUTLETS PER SWITCH ABOVE, APPROX. 4'-0" LONG WHEN EXTENDED AND 1/2" WHEN NOT EXTENDED. TYPICAL FOR EACH RECEIVING AREA.
- * PROVIDE SLEEPER PITCHES IN EACH LIVING ROOM.
- * PROVIDE ADA ACCESSIBLE RESTROOMS AS SHOWN ON SFT PLAN.
- * PROVIDE DATA DROPS IN HOUSING AS SHOWN ON PLAN.

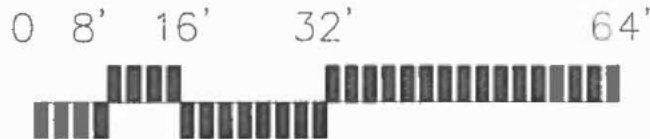


CHAPELS



* ALL OUTLETS IN REACH OF CHILDREN SHALL BE COVERED
NON-TAMPER TYPE OUTLETS
* PROVIDE DATA AND VOICE DROPS IN ALL OFFICES PER ICC
STANDARDS.

SCALE 1/32"



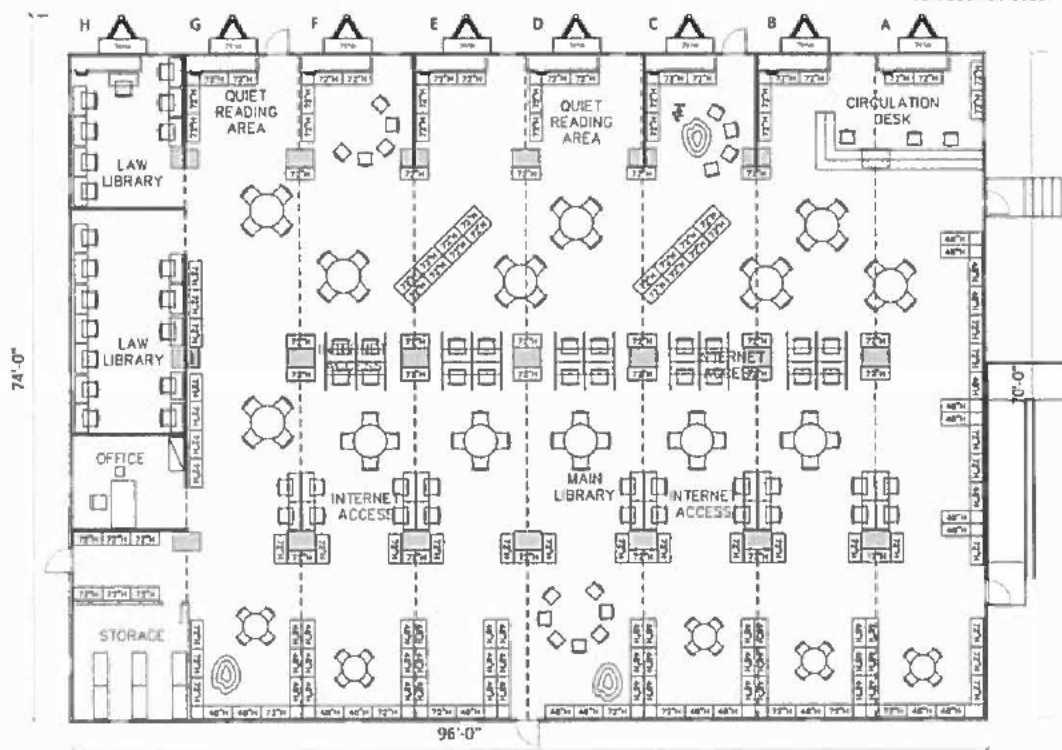
LEISURE LIBRARY/LAW LIBRARY



Visit Us On The Web:
www.satellitetele.com
800-453-1299

96'x74' COMPLEX-RR
(Box Size 96'x70')
S/N 6977-A-B-C-D-E-F-G-H
04/23/14

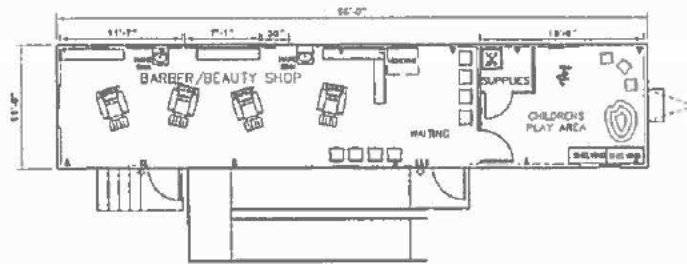
Satellite Shelters Inc.
Houston Branch
18500 Van Rd. Houston, Tx 77049
Phone: 281-456-0457
Fax: 281-456-8925



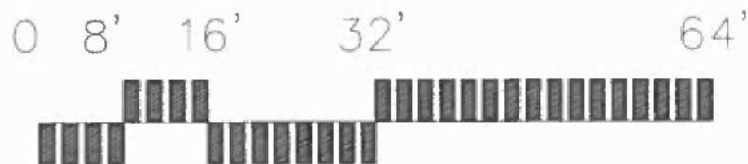
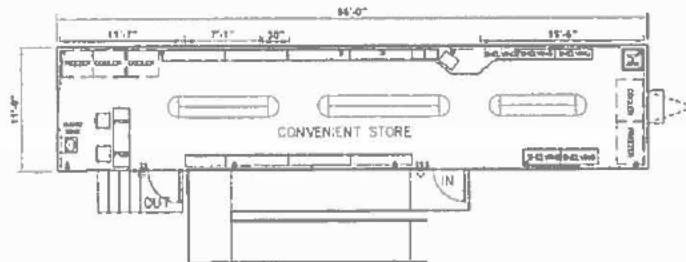
- * ALL OUTLETS IN REACH OF CHILDREN SHALL BE COVERED NON TAMPER TYPE OUTLETS.
- * PROVIDE DATA AND VOICE DROPS FOR ALL TERMINALS PER ICE STANDARDS.
- * PROVIDE "LEXUS NEXUS" ON ALL CPU'S



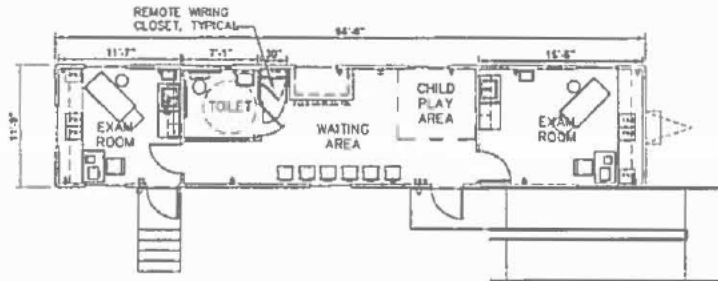
BARBER/BEAUTY SHOP



CONVENIENT STORE



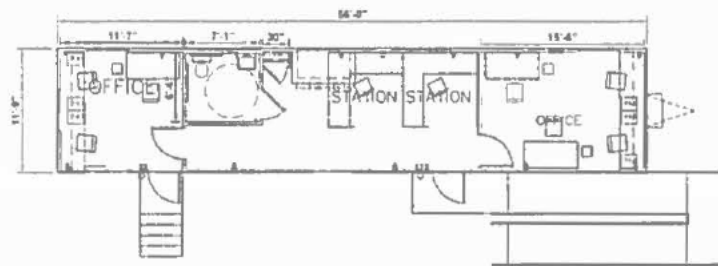
MEDICAL TRIAGE



- PROVIDE DATA AND VOICE DROPS IN EACH EXAM ROOM TYP
- ALL MEDICAL TRIAGE BUILDINGS INCLUDING RESTROOMS SHALL BE ADA COMPLIANT WITH ACCESSIBLE ACCESS PATHS.
- PROVIDE HANDWASH SINK IN ALL EXAM ROOMS, TYP
- PROVIDE HAND WASHING "PURELL" TYPE STATION AT EACH ENTRY/EXIT POINT TYP



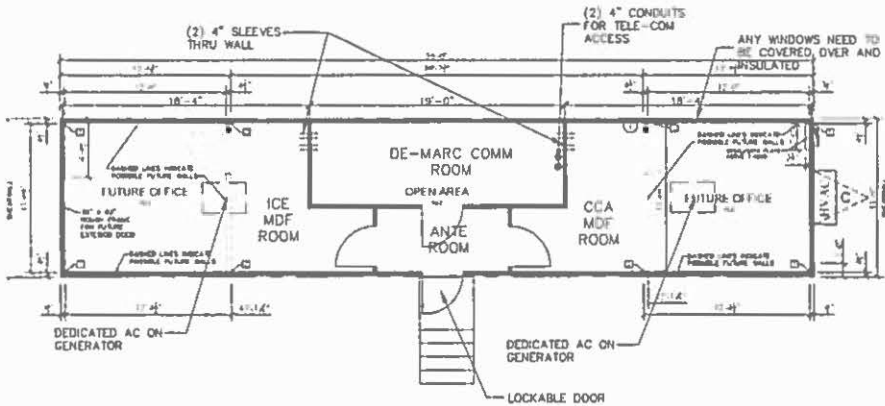
CCA UNIT MANAGER



- PROVIDE DATA AND VOICE DROPS IN EACH EXAM ROOM TYP



ICE/CCA MDF ROOM



An extra 3/4" layer would be helpful as the IT equipment can get very heavy. VCT covering would be fine.

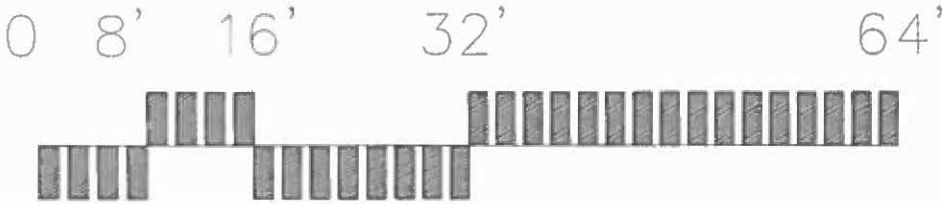
The VCG would be fine for most of the areas. In the Dmarc/CommRoom, we would need 4'x8'x3/4" plywood mounted to 3 of the walls. Then in each MDF (CCA and ICE) we would need 2 plywood panels on the back wall (both mounted horizontally) mounted 2' AFF.

For each IDF (i.e. all the other buildings) need to have 4'x4'x3/4" mounted to the wall where we can mount our IT cabinets with the bottom of the panel at 48" AFF.

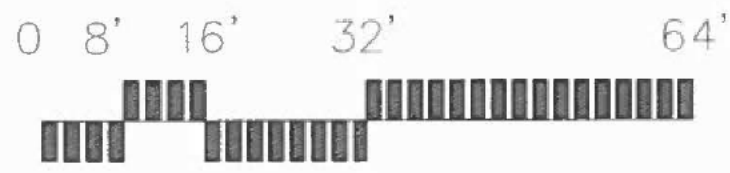
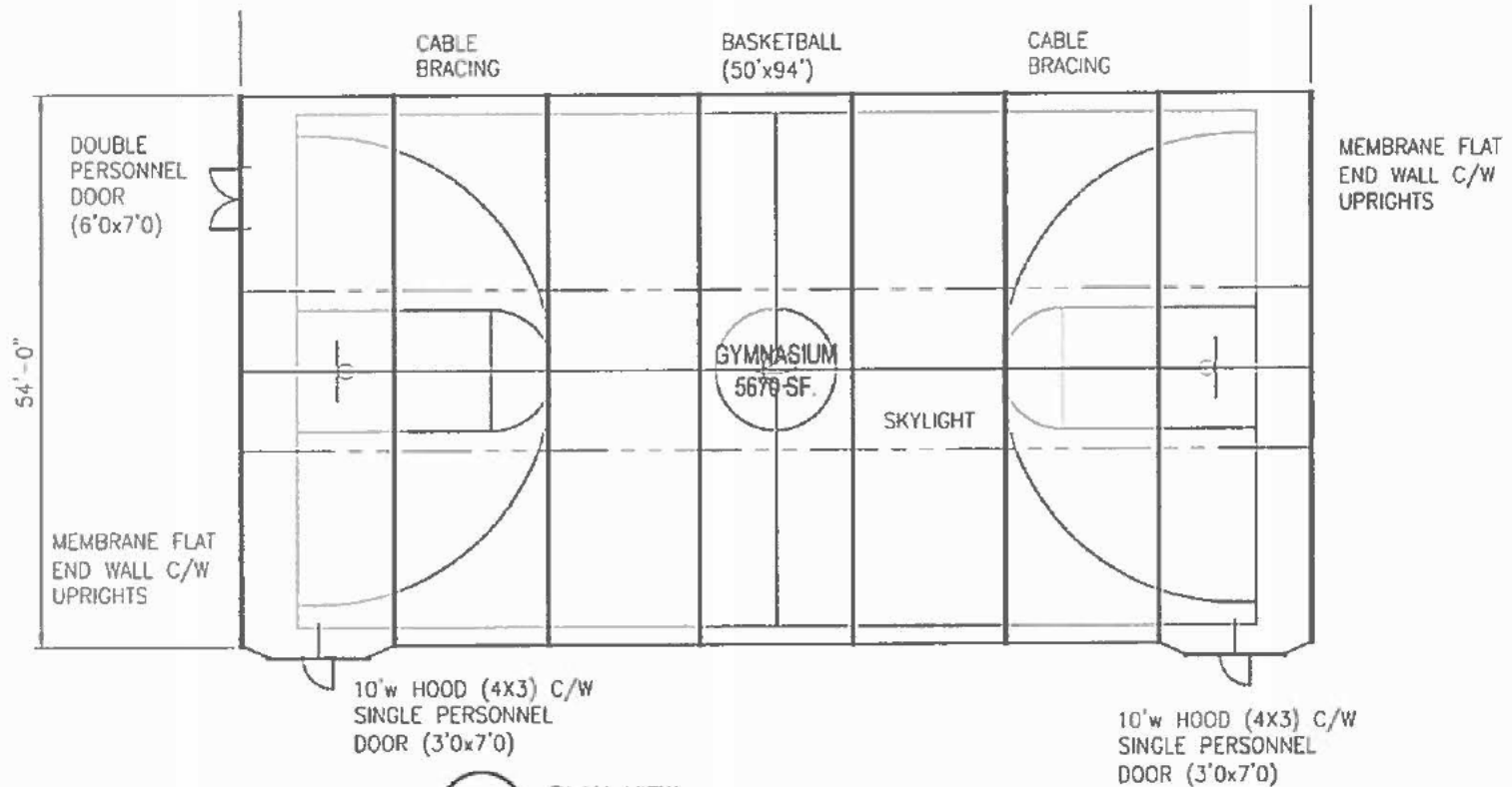
All these plywood panels need to be fire rated.

Additional pier support would be very helpful.

As far as the A/C, the equipment will need to be rated for data center/server room which is expected to run 24x7. Typical max temperature is 68-70 deg.



INDOOR GYMNASIUM



CHILD CARE LICENSING REQUEST FOR BACKGROUND CHECK

GCL

"Texas law gives you the right to know what information is collected about you by means of a form you submit to a state government agency. You can receive and review this information, and request that incorrect information about you be corrected by contacting your licensing representative."

Operation Name: South Texas Family Residential Center (CCA South Texas, LLC) authorized under the name of Corrections Corporation of America South Texas, LLC (File Number 802074158)		Operation Number	Telephone No. (A/C) 870-378-8500
Operation Address (Street, City, ZIP) 1925 West Hwy 85, Dilley, Texas 78017		Operation Mailing Address (City & Zip) 1925 West Hwy 85, Dilley, Texas 78017	County Frio

Complete the following information for each person required to have a background check. All names used currently or in the past must be provided. If you do not provide every name that each person has used, you may receive inaccurate results. Additional forms may be obtained from the Licensing office.

I verified (by reviewing the person's social security card and/or driver license) that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge. I understand that the Department may contact others and, at any time, seek proof of any information contained here. I understand that any willful misrepresentation or failure to provide identifying information within the stated time limit is a cause for denial of the application or revocation of any license, registration or listing.

Janice Killian, Facility Administrator *Janice Killian* 10/31/14
 Printed Name of Director, Owner, or Operator Signature of Director, Owner, or Operator Date

Initial 24 Month Check Fingerprint Check Required FBI Results in DPS Clearinghouse

Social Security Number: [Redacted] ID Type - Driver's License or ID Number - State: [Redacted]

First Name: Janice Middle Name: Mary Last Name: Killian
 Street Address: 1011 Creston Park City: Hutto State: Texas Zip: 78634
 County: Williamson Telephone No. (A/C): [Redacted] Date of Birth: [Redacted] Gender: M F

You must list any other city in Texas where this person has been a resident, and any addresses, including county, where the person has lived outside of Texas in the previous five years:

Relationship of person to requestor
 Adoptive Parent Caregiver Director Foster parent Household Member Licensed Administrator
 Other Staff Staff Volunteer Other: Facility Administrator

For Foster/Adoptive Homes only: Relationship between child/children to be placed and the foster/adoptive parent(s) or prospective foster/adoptive parent(s) Relative Fictive Kin Unrelated

Date Hired /Used by the Operation/Agency: 10/24/2010
 Ethnicity (must accompany race) Hispanic Other
 Race White Black Unable to Determine Asian American Indian/Alaskan Native Native Hawaiian/ Pacific Islander

Other names used (married, maiden, etc.) First Name: Middle Name: Last Name:

DFPS Use Only Worker Name - Last, First Mail Code



REQUEST FOR CHILD ABUSE/NEGLECT CENTRAL REGISTRY

CHIEF OPERATING OFFICER – CENTRALIZED BACKGROUND CHECK UNIT

Purpose: An individual may use this form to request a Texas Department of Family and Protective Services Central Registry Abuse and Neglect check on him or herself. Central Registry requests from out of state protective service agencies needed to assist an investigation or other case action must be faxed on your state agency's letterhead to SWI: 800-647-7410 or 512-339-5900.

Directions: The Requestor/Subject of the background check must read and complete Sections 1-6 (Section 5 should only be completed if applicable), then notarize and submit this form using the instructions below. If you have questions, email: TXAbuseNeglectBGC@dfps.state.tx.us or call the CBCU Support Line at (800) 645-7549. Typically, DFPS provides the background check results within 30 days of receipt.

Instructions: Complete, notarize and submit this form to (email, fax or mail below):
 Email: TXAbuseNeglectBGC@dfps.state.tx.us Mail: CBCU TX Abuse Neglect BGC, M/C 121-7
 FAX: 512-339-5829 PO Box 149030, Austin, TX 78714-9030

SECTION 1: CENTRAL REGISTRY INFORMATION

As required by Texas Family Code §261.002, DFPS maintains a central registry of reported cases of child abuse and neglect. The DFPS Central Registry includes information gathered during Child Protective Services (CPS), Child Care Licensing (CCL), and Adult Protective Services (APS) facility investigations of child abuse and neglect that resulted in a disposition of "reason to believe" for CPS and CCL cases or "confirmed and validated" for APS cases. (Findings of abuse, neglect, or exploitation of an adult victim are not included in the Central Registry.)

You will not clear the Central Registry check if you:

- Have the role of designated perpetrator or sustained perpetrator in an investigation included in the registry; or
- Are involved as an alleged perpetrator in an open child abuse or neglect investigation being conducted by DFPS. A new Central Registry check may be requested at the conclusion of the investigation to determine if you were designated as a perpetrator of child abuse or neglect.

As the subject of the request, you have the right to receive the results of this check and to share them with any third party.

If the check results in a match as described above, DFPS will only send the results directly to you via mail or email unless you identify a designee who is a Social Study Evaluator or representative with the Office of Refugee Resettlement (ORR), as provided in Section 4.

SECTION 2: REQUESTOR/SUBJECT OF THE BACKGROUND CHECK:

The information in this section must be provided by the requestor/subject of the background check in order for the check to be completed. Missing information may result in a delay of your request being processed.

First Name Janice	Middle Name Mary	Last Name Killian
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Other names or spellings used (married, maiden, alias, etc.) - First, Middle, Last (continue on back as needed)

Current Address 1011 Creston Cove	City Hutto	County Williamson	State TX	Zip Code 78634
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Social Security Number (required): [REDACTED]	Date of Birth (required): [REDACTED]	Gender: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	Telephone number: 512-529-2419
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Ethnicity <input type="checkbox"/> Hispanic <input checked="" type="checkbox"/> Other	Race <input checked="" type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Unable to Determine	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander
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List any other additional addresses or cities in Texas that you have resided (continue on back as needed)

If you would like a copy of these results sent to you, please select the appropriate box.

- Email (preferred method): _____
 Mail (results will be sent to the mailing address listed above)

SECTION 3: SIGNATURES

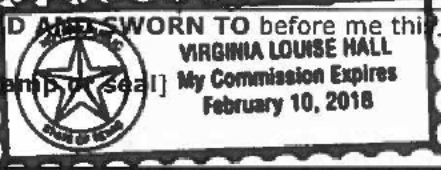
This section of the form must be signed by the requestor/subject of the background check and not the designee. This form must be signed in the presence of the Notary Public.

- I am the person listed above in Section 2 of this form. The information in this document is correct.
- If applicable, I grant permission for the results of my Child Abuse/Neglect Central Registry check to be transmitted to the designee I listed in Section 5.
- I authorize DFPS to transmit the results of this background check via email, and I acknowledge that DFPS cannot guarantee that information transmitted electronically is secure and accessible only to approved parties.
- I understand that the information I am providing will be part of any request and that providing false information is a violation of Texas Penal Code Section 37.10.
- I acknowledge that my designee can receive my background check results only as described in Section 1 and 4 of this form.

Requestor: *Janice K. [Signature]* Date Signed: 9/11/15
X

SUBSCRIBED AND SWORN TO before me this 1st day of September 2015.

[Notary stamp or seal]



[Signature]
Notary Public

SECTION 4: PURPOSE OF CENTRAL REGISTRY REQUEST

1. Individual currently seeking Central Registry clearance for the placement of a child.
 Check here if you are a Social Study Evaluator identified in Texas Family Code § 107.05145. Social Study Evaluators who meet certain requirements under Texas law may be required to provide valid picture identification and the court order identifying the evaluator as the authenticated designee before DFPS will release results.
 Check here if your request is to support the placement of an unaccompanied minor currently in ORR's care with a sponsor, and ensure waiver form is attached with 2970 form for each person requiring the background check.
2. Employment/Volunteer: please provide name of organization and why the background check is being requested _____

For purpose #1 only, requestors can list a designee to whom DFPS will send the results. (See section 5)

For purpose #2, DFPS cannot release the results to any person other than the subject of the background check.

**SECTION 5: DESIGNESS
THIS SECTION ONLY APPLIES TO PURPOSE #1 ABOVE**

SEND RESULTS OF REQUESTED CHECKS TO DESIGNEE:

Full Name	Email Address	Phone Number			
Address	City	County	State	Zip Code	

Please indicate below the agency or entity the designee represents:

SECTION 6: PRIVACY STATEMENT

DFPS values your privacy. For more information, read our [privacy policy](#).



Office of the Secretary of State

The undersigned, as Secretary of State of Texas, does hereby certify that the document, Application for Registration for CCA SOUTH TEXAS, LLC, authorized under the name Corrections Corporation of America South Texas, LLC (file number 802074158), a MARYLAND, USA, Foreign Limited Liability Company (LLC), was filed in this office on September 30, 2014.

It is further certified that the entity status in Texas is in existence.

IT IS FURTHER CERTIFIED that a diligent search of the records of this office reveals that the following described documents are on file as of this date for such entity:

Application for Registration
Certificate of Assumed Business Name

September 30, 2014
November 25, 2014

In testimony whereof, I have hereunto signed my name officially and caused to be impressed hereon the Seal of State at my office in Austin, Texas on July 07, 2015.



A handwritten signature in black ink, appearing to read "Cascos" followed by a horizontal line.

Carlos H. Cascos
Secretary of State

STATE OF MARYLAND
Department of Assessments and Taxation

I, PAUL B. ANDERSON OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF THE STATE OF MARYLAND, DO HEREBY CERTIFY THAT THE DEPARTMENT, BY LAWS OF THE STATE, IS THE CUSTODIAN OF THE RECORDS OF THIS STATE RELATING TO LIMITED LIABILITY COMPANIES, OR THE RIGHTS OF LIMITED LIABILITY COMPANIES TO TRANSACT BUSINESS IN THIS STATE, AND THAT I AM THE PROPER OFFICER TO EXECUTE THIS CERTIFICATE.

I FURTHER CERTIFY THAT CCA SOUTH TEXAS, LLC, REGISTERED SEPTEMBER 23, 2014, IS A LIMITED LIABILITY COMPANY EXISTING UNDER AND BY VIRTUE OF THE LAWS OF THE STATE OF MARYLAND, AND THAT THE LIMITED LIABILITY COMPANY IS AT THE TIME OF THIS CERTIFICATE IN GOOD STANDING TO TRANSACT BUSINESS.

IN WITNESS WHEREOF, I HAVE HEREUNTO SUBSCRIBED MY SIGNATURE AND AFFIXED THE SEAL OF THE STATE DEPARTMENT OF ASSESSMENTS AND TAXATION OF MARYLAND AT BALTIMORE ON THIS JULY 07, 2015.



Paul B. Anderson
Charter Division



301 West Preston Street, Baltimore, Maryland 21201
Telephone Balto. Metro (410) 767-1340 / Outside Balto. Metro (888) 246-5941
MRS (Maryland Relay Service) (800) 735-2258 TT/Voice
Fax (410) 333-7097

VERIFICATION OF INSURANCE

Operation Name South Texas Family Residential Center	Operation No	Telephone No 830-678-6500
Address 300 El Rancho Way		
Licensee South Texas Family Residential Center	Type of Operation General Residential Operation Emergency Shelter	

This operation has liability insurance in the amount of \$300,000 for each occurrence of negligence covering injury to a child. (A copy of the Certificate of insurance must be attached.)

Insurance Company Name Marsh USA	Policy No [REDACTED]	Policy Coverage Dates From: 04/01/2015 To: 04/01/2016
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This operation does not have liability insurance as required by Section 42.049 of the Human Resources Code for the following reason:

Financial reasons (cannot afford). Give reason: _____

No coverage available from an underwriter. Give reason why: _____

The limitations on the current policy have been exhausted.

When will it be available? _____

Exempt as agency home, licensed or registered day care home, listed family home, state operated facility or independent school district operation.

Parents of children in care have been, or will be, notified in writing by the following means:

Pamphlet to parents. (Attach a copy.)

Notice posted in a prominent place. (Attach a copy.)

Letter to parents. (Attach copy of letter.)

A statement is on the enrollment form. (Attach a copy of the enrollment form.)

Other (specify): _____



Signature-Director/Designee

09/02/2015
Date

This operation has liability insurance for each occurrence of negligence covering injury to a child.


Janice Killian
Facility Administrator



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
03/31/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA, Inc. 1801 West End Avenue, Suite 1500 Nashville, TN 37203 Attn: Connie Stewart - connie.d.stewart@marsh.com 433577-CCA-PROF-15-16	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL: ADDRESS:	FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE	
INSURED Corrections Corporation of America 10 Burton Hills Blvd. Nashville, TN 37215	INSURER A: Zurich American Insurance Company	NAIC #: 16535
	INSURER B: National Union Fire Ins Co Pittsburgh PA	NAIC #: 19445
	INSURER C: New Hampshire Insurance Company	NAIC #: 23841
	INSURER D: Steadfast Insurance Company	NAIC #: 26387
	INSURER E: Illinois National Insurance Company	NAIC #: 23817
	INSURER F:	NAIC #:

COVERAGES	CERTIFICATE NUMBER: ATL-003257189-10	REVISION NUMBER: 7
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THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR / WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC		SIR. \$2,000,000	04/01/2015	04/01/2016	EACH OCCURRENCE \$ 5,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 5,000,000 GENERAL AGGREGATE \$ 15,000,000 PRODUCTS - COMP/OP AGG \$ 5,000,000
B	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS		SIR. \$500,000	04/01/2015	04/01/2016	COMBINED SINGLE LIMIT (Ea accident) \$ 2,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
D	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$			04/01/2013	04/01/2016	EACH OCCURRENCE \$ 25,000,000 AGGREGATE \$ 25,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	04/01/2015	04/01/2016	<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
C	Workers Compensation			04/01/2015	04/01/2016	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Evidence of insurance

CERTIFICATE HOLDER Corrections Corporation of America 10 Burton Hills Blvd Nashville, TN 37215	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Jimmy Evans
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ADDITIONAL REMARKS SCHEDULE

AGENCY Marsh USA, Inc.		NAMED INSURED Corrections Corporation of America 10 Burton Hills Blvd Nashville, TN 37215	
POLICY NUMBER		EFFECTIVE DATE:	
CARRIER	NAIC CODE		

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
 FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Hospital Professional Liability:

Policy Number: XXXXXXXXXX
 Effective Date: 04/01/2015
 Expiration Date: 04/01/2016
 Specified Loss Limit: \$5,000,000
 Aggregate: \$10,000,000
 SIR: \$2,000,000

RESIDENTIAL CHILD CARE LICENSE FEE SCHEDULE

Please check if this is a change of address.

Operation Name: South Texas Family Residential Center		Operation Number (on your permit): If this is a new operation, check this box <input checked="" type="checkbox"/>		Telephone Number 830 - 678 - 6500
Operation Street Address: 300 El Rancho Way		City: Dilley	County: FRIO	Zip 78017
E-Mail Address: janice.killian@cca.com				
TYPE OF FEE BEING PAID				AMOUNT
Operation Type (check one)	Fee Type (check all that apply)			
<input checked="" type="checkbox"/> General Residential Operation <input type="checkbox"/> Child-Placing Agency <input type="checkbox"/> Independent Foster Home	<input checked="" type="checkbox"/> Application <input checked="" type="checkbox"/> Initial <input type="checkbox"/> Initial Renewal See Amount Below <input type="checkbox"/> Non-expiring license fee <input type="checkbox"/> Annual Renewal			\$ 70
<input type="checkbox"/> Amendment -- Increased capacity only; \$1 for each additional child: _____ x \$1				\$ _____
CAPACITY. Number of children for which you are licensed: 1500 x \$1 (Only paid with a non-expiring license fee or annual renewal).				\$ 1500
<input checked="" type="checkbox"/> Background Check Fee	Number of Persons being checked: 1050 x \$2			\$ 2100
TOTAL AMOUNT OF FEES PAID:				\$ 3670

FEE DEFINITIONS

Application Fee: A nonrefundable fee of \$35 for an initial application for a license to operate a child care operation or child-placing agency. This fee is paid when the application is submitted.

Initial License Fee: A \$35 fee for a child care operation (other than a child-placing agency). A \$50 fee for a child-placing agency. This fee is paid when the application is submitted.

Initial Renewal: \$35.00 fee for a child care operation. A \$50 fee for a child-placing agency. The fee is paid when the initial license is renewed.

Non-expiring licensing fee and annual fee: A \$35 fee for a child care operation plus \$1 for each child the operation is licensed to serve (other than a child-placing agency); a \$100 fee for a child-placing agency. This fee is paid before the non-expiring license is issued and at the anniversary date of issuance.

Directions for Sending Payment: (Copy) Payment sent to Austin.

1. Please send only **ONE CHECK or MONEY ORDER** for the entire amount (including any background check fees).
Please DO NOT SEND CASH
2. Make check or money order payable to:

Department of Family and Protective Services
3. Mail this completed form and your check or money order to:

Texas Department of Family and Protective Services
Licensing Fee
Accounting Division E-672
P.O. Box 149030
Austin, Texas 78714-9030
4. Keep a copy of your canceled check or money order for your records. **NO RECEIPT WILL BE SENT**

Note: This form and your payment will be returned to you if:

- The form is blank or incomplete;
- You do not send the correct fee amount; or
- You send cash

The law requires that if an operation fails to pay the annual license fee when due, the license will be suspended until the fee is paid. This means children must not be in care at the operation until the suspension is lifted. State Law requires the Texas Department of Family and Protective Services to collect fees for issuing licenses, registrations and listings and for conducting background checks. Fees received by the Department are deposited in the state's general revenue fund.

Controlling Person Form Child Care Licensing

Operation Name South Texas Family Residential Center		Operation Number	Telephone No. (A/C) 830-678-6500
Address of Operation 300 El Rancho Way		City & ZIP Code Dilley 78017	County Frio

Complete the required information for each controlling person with your operation. This includes all people in the operation as stated under 40 TAC §745.901 or see Page 3 of this form for the definition of "controlling person."

The information on this form contains no willful misrepresentation. The information given is true and complete to the best of my knowledge. I understand that any willful misrepresentation or failure to provide identifying information within the required time frames is a cause for remedial action regarding my application or permit.

Janice M Killian
Signature of Applicant, Designee, or Head of Governing Body

9/15/15
Date

First Name Janice		Middle Name Mary		Last Name Killian		Suffix
Other names used (married, maiden, etc.) First Name NA		Middle Name NA		Last Name Keyes		Suffix
Date of Birth [REDACTED]	Driver's License No. [REDACTED]	Driver's License State [REDACTED]	SSN [REDACTED]			
Individual's Mailing Address 1011 Creston Cove		City Hutto	State TX	Zip 78634	Telephone No. (A/C) 512-529-2419	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input checked="" type="checkbox"/> Center Director <input type="checkbox"/> Board Member <input type="checkbox"/> Governing Body Member <input type="checkbox"/> CEO <input type="checkbox"/> Owner <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position 09-02-2015
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____						

First Name Lana		Middle Name Kay		Last Name Veazey		Suffix
Other names used (married, maiden, etc.) First Name NA		Middle Name NA		Last Name Drenser		Suffix
Date of Birth [REDACTED]	Driver's License No. [REDACTED]	Driver's License State [REDACTED]	SSN [REDACTED]			
Individual's Mailing Address 3104 River Cove		City Belton	State TX	Zip 76513	Telephone No. (A/C) 254-206-0052	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input type="checkbox"/> Center Director <input type="checkbox"/> Board Member <input checked="" type="checkbox"/> Governing Body Member <input type="checkbox"/> CEO <input type="checkbox"/> Owner <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position 09-02-2015
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____						

DFPS Use Only	Name of Licensing Staff Completing AARS Check		Mail Code
Date Form Received	Date AARS Check Completed	AARS Status: Cleared: Match:	

Controlling Person Form Child Care Licensing

First Name Wesley		Middle Name Jullian		Last Name Lee		Suffix	
Other names used (married, maiden, etc.) First Name NA		Middle Name NA		Last Name NA		Suffix	
Date of Birth [REDACTED]	Driver's License No. [REDACTED]	Driver's License State [REDACTED]	SSN [REDACTED]				
Individual's Mailing Address 1160 West Hwy 85			City Dilley	State TX	Zip 78017	Telephone No. (A/C) 830-965-6176	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input checked="" type="checkbox"/> Governing Body Member <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Center Director <input type="checkbox"/> CEO <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Board Member <input type="checkbox"/> Owner <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position 09-02-2015	
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____							

First Name Barbara		Middle Name Jean		Last Name Seidl Schreier		Suffix	
Other names used (married, maiden, etc.) First Name Barb		Middle Name NA		Last Name Seidl		Suffix	
Date of Birth [REDACTED]	Driver's License No. [REDACTED]	Driver's License State [REDACTED]	SSN [REDACTED]				
Individual's Mailing Address 501 Northwood Drive			City Redwood Falls	State MN	Zip 56283	Telephone No. (A/C) 320-413-0198	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input checked="" type="checkbox"/> Governing Body Member <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Center Director <input type="checkbox"/> CEO <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Board Member <input type="checkbox"/> Owner <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position	
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____							

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First Name Tamara		Middle Name Marie		Last Name Jordan		Suffix	
Other names used (married, maiden, etc.) First Name NA		Middle Name NA		Last Name NA		Suffix	
Date of Birth [REDACTED]	Driver's License No. [REDACTED]	Driver's License State [REDACTED]	SSN [REDACTED]				
Individual's Mailing Address PO Box 18089			City Dilley	State TX	Zip 78017	Telephone No. (A/C) 229-315-1254	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input checked="" type="checkbox"/> Governing Body Member <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Center Director <input type="checkbox"/> CEO <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Board Member <input type="checkbox"/> Owner <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position	
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____							

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First Name		Middle Name		Last Name		Suffix	
Other names used (married, maiden, etc.) First Name		Middle Name		Last Name		Suffix	
Date of Birth	Driver's License No.	Driver's License State	SSN				
Individual's Mailing Address			City	State	Zip	Telephone No. (A/C)	
Title, Position or Relationship <input type="checkbox"/> Licensed Administrator <input type="checkbox"/> Governing Body Member <input type="checkbox"/> Primary Caregiver in Child Care Home <input type="checkbox"/> Center Director <input type="checkbox"/> CEO <input type="checkbox"/> Spouse of Primary Caregiver <input type="checkbox"/> Board Member <input type="checkbox"/> Owner <input type="checkbox"/> Adult Living in Child Care Home <input type="checkbox"/> Other: _____						Effective Date of Position	
If person is associated with a Child Placing Agency, indicate if the person is associated with the Main or Branch office: <input type="checkbox"/> Main <input type="checkbox"/> Branch If Branch, what number: _____							