KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
Community Services and Programs - Behavioral Health Services
500 SW Kansas Ave
Topeka, Kansas 66603
Phone (785) 296-3471 Fax (785) 296-0256
Website: www.kdads.ks.gov

REQUEST FOR AMENDMENT

Type of Facility:

___ Psychiatric Residential Treatment Facility

Please complete the following and return to Kansas Department for Aging and Disability Services.
I am requesting an Amendment to my License #_____ Current Total Capacity: _____ Requested Total Capacity: ____

Current:				**Requested:**			
Name of Unit/Cottage	Capacity	Sex	Age Range	Name of Unit/Cottage	Capacity	Sex	Age Range

If request is to: [check all that apply] ___ increase license capacity; ___to provide care for younger children [preschool or infants/toddlers]; or ___includes adding space or remodeling existing space, I/we have enclosed a copy of the Kansas State Fire Marshall approval of the proposed change. ___Yes ___No

If Request is to increase license capacity or to expand age range or to change the living units, I/we have enclosed a copy of the notification and of the receipt of the required notification to the local school district in accordance with K.A.R. 28-4-269(m). ___Yes ___No

Describe the reason for the request: [Use a separate page, it needed.]

Name of Facility License Number Address Cit y Zip County

Telephone Number Fax Number Email Address Date

Operator Address Cit y Zip County

MUST BE COMPLETED BY THE QUALITY IMPROVEMENT FIELD STAFF FOR RESIDENTIAL FACILITIES:

Quality Improvement Field Staff Recommendation: Approve: _____ Disapprove: _____ Reason(s):

Signature of Quality Improvement Field Staff Date

KDADS Administrator Response: Approve: _____ Disapprove: _____ Comment(s):

Signature Date