



Municipality of Anchorage
 DEPARTMENT OF HEALTH & HUMAN SERVICES
 825 "L" Street • Anchorage, Alaska 99501 • Telephone 343-6718



APPLICATION TO OPERATE A COLD WEATHER SHELTER

Designation is at the discretion of the Director of the Department of Health & Human Services, or their designee. Satisfaction of the requirements in AMC CHAPTER 16.120 does not guarantee designation.

APPLICANT

Date of Application:	Name of Organization:	<input type="checkbox"/> Church <input type="checkbox"/> Social Service Agency <input type="checkbox"/> Other		
Physical Address:		City:	State:	Zip:
Mailing Address (<i>only if different from physical</i>):		City:	State:	Zip:
Primary Contact Person:	Phone:	Work:	Cell:	Email:
Alternate Contact Person:	Phone:	Work:	Cell:	Email:

GENERAL FACILITY INFORMATION

Maximum Occupancy Load	"Are children's/preschool services offered in this facility?"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shelter Will House (<i>check all that apply</i>)			
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Families	<input type="checkbox"/> Teens

ATTACHMENTS

- ◆ Copy of Insurance Certificate (*required*) ◆ Plan of Operations For Sheltering (*required*)
- ◆ Copy of Last AFD Inspection (*required*) ◆ Red Cross Certification For The Facility (*if applicable*)

APPLICANT AUTHORIZATION AND SIGNATURE

By signature below, I certify that I am authorized by the church/organization named above to submit this application on its behalf and that I have read Anchorage Municipal Code, Chapter 16.120, and the Municipality's Cold Weather Plan for Homeless Persons (The Plan), and agree, on behalf of the church/organization named above, to abide by all requirements of AMC Chapter 16.120, The Plan, the Anchorage Fire Department and the Department of Health & Human Services. In consideration of the protection afforded by AMC chapter 16.120 and designation as a participant in the Municipality's Cold Weather Plan for Homeless Persons, the Applicant hereby consents to and does hereby agree to indemnify, defend, save and hold the MOA and its' employees and agents harmless from any claims, lawsuits, or liability, including attorney's fees and costs, allegedly arising out of loss, damage or injury to the Applicant and its' employees, customers or congregants, occurring during the course of or as a result of the Applicant's participation in The Plan.

Signature:	Printed Name:	Date Signed:
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APPROVALS

Anchorage Fire Department		
<input type="checkbox"/> Approved	Signature: _____	Printed Name: _____ Date: _____
<input type="checkbox"/> Not Approved	Reason: _____	Date: _____
DHHS Staff		
<input type="checkbox"/> Approved	Signature: _____	Printed Name: _____ Date: _____
<input type="checkbox"/> Not Approved	Reason: _____	Date: _____
DHHS Director		
<input type="checkbox"/> Approved	Signature: _____	Printed Name: _____ Date: _____
<input type="checkbox"/> Not Approved	Reason: _____	Date: _____

Designation is for a 24 month period. It is the responsibility of the applicant, or their agent, to contact DHHS 90 days before expiration of their designation, and apply for renewal.	Beginning Date	Ending Date