Municipality of Anchorage
ANCHORAGE HEALTH DEPARTMENT
825 L Street • Anchorage, Alaska 99501 • (907) 343-6718
housingandhomelessservices@anchorageak.gov

APPLICATION TO OPERATE AN EMERGENCY SHELTER

APPLICANT INFORMATION

Application Date	Name of Organization	☐ Church ☐ Social Service Agency ☐ Other (specify) ______		
Physical Address		**City**	**State**	**Zip**
Mailing Address *(if different from physical):*		**City**	**State**	**Zip**

Primary Contact Person	Work Phone	Cell Phone	Email
Alternate Contact Person	**Work Phone**	**Cell Phone**	**Email**

FACILITY INFORMATION

Population(s) Served at Shelter ***(check all that apply)***	☐ Single Adult ☐ Adult Couple ☐ Family with Children ☐ Young Adult (18-24)	☐ Male ☐ Female ☐ Transgender	***Special populations*** ☐ Medically Fragile ☐ LGBTQIA+ ☐ Other (specify) ______

Maximum Occupancy	Are children's/preschool services offered in this facility? ☐ Yes ☐ No

ATTACHMENTS

- **Copy of Insurance Certificate** (*required*)
- **Copy of Recent Fire Department Inspection** (*required*)
- **Operations Plan for Shelter** (*required*)
  See Guidance Document for required components
- **Red Cross Certification for the Facility** *(if applicable)*

APPLICANT AUTHORIZATION AND SIGNATURE

See the Application Guidance Document that accompanies this form to review the required information.

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 Emergency Shelter Plan for Persons Experiencing Homelessness #10-001 (The Plan), and agree, on behalf of the organization named above, to abide by all requirements of AMC Chapter 16.120, The Plan, the Anchorage Fire Department and the Anchorage Health Department. In consideration of the protection afforded by AMC chapter 16.120 and designation as a participant in The Plan, 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

	Start Date	End Date
1. **Designation is at the discretion of the Health Department Director, or their designee. Meeting the requirements in AMC Chapter 16.120 does not guarantee designation.** 2. **Designation is for a 24-month period. It is the responsibility of the applicant, or their agent, to contact AHD 90 days before designation expires and to apply for renewal.**		

APPROVALS

Anchorage Fire Department

Approved Signature ______ Print Name ______ Date ______

Not Approved Reason

Anchorage Health Department Program Manager

Approved Signature ______ Print Name ______ Date ______

Not Approved Reason

Anchorage Health Department Director

Approved Signature ______ Print Name ______ Date ______

Not Approved Reason