

Application for License to Operate a Behavioral Health Services Organization

OIG 20:430 – October 2014 edition

I. Type of Application:

- | | |
|---|--|
| <input type="checkbox"/> Initial Licensure Application (\$750 Fee)
<input type="checkbox"/> Renewal Application (\$500 Fee)
<input type="checkbox"/> Adding an Extension Location (\$250 Fee) | <input type="checkbox"/> Change of Ownership (\$750 Fee)
<input type="checkbox"/> Change of Location (\$100 Fee)
<input type="checkbox"/> Change of Name (\$25 Fee), Effective Date: _____ |
|---|--|

II. Type of Services Provided:

- | | |
|--|---|
| <input type="checkbox"/> Screening
<input type="checkbox"/> Assessment
<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Crisis Intervention
<input type="checkbox"/> Mobile Crisis Services
<input type="checkbox"/> Day Treatment
<input type="checkbox"/> Peer Support
<input type="checkbox"/> Intensive Outpatient Program Services
<input type="checkbox"/> Individual Outpatient Therapy
<input type="checkbox"/> Group Outpatient Therapy
<input type="checkbox"/> Family Outpatient Therapy
<input type="checkbox"/> Collateral Outpatient Therapy | <input type="checkbox"/> Service Planning
<input type="checkbox"/> Residential Services for Substance Use Disorders
<input type="checkbox"/> Screening, Brief Intervention and Referral to Treatment for Substance Use Disorders
<input type="checkbox"/> Assertive Community Treatment for Mental Health Disorders
<input type="checkbox"/> Comprehensive Community Support Services
<input type="checkbox"/> Therapeutic Rehabilitation Program for an Adult with a Serious Mental Illness or Child with a Severe Emotional Disability
<input type="checkbox"/> Targeted Case Management Services |
|--|---|

Does your facility employ or have an affiliation with a physician or physicians who prescribe suboxone for the treatment of opioid addiction?

- Yes No

Is your facility currently licensed by the Division of Regulated Child Care as a private child-caring or private child-placing agency?

- Yes No

Is your facility currently licensed by the Division of Health Care as an alcohol and other drug abuse treatment program?

- Yes No

NOTE: A behavioral health services organization must obtain separate licensure as an alcohol and other drug abuse treatment program (AODE) if the organization provides any one of the following services for the treatment of individuals with a substance use disorder or co-occurring disorder in which substance use disorder is the primary diagnosis:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Screening • Assessment • Crisis Intervention • Mobile Crisis Services • Day Treatment • Peer Support • Intensive Outpatient Program Services | <ul style="list-style-type: none"> • Individual Outpatient Therapy • Group Outpatient Therapy • Family Outpatient Therapy • Collateral Outpatient Therapy • Residential Services for Substance Use Disorders • Screening, Brief Intervention and Referral to Treatment • Targeted Case Management |
|--|--|

HOURS OF OPERATION

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
--------	---------	-----------	----------	--------	----------	--------

III. IDENTIFICATION:

License Number: _____
(Not applicable if this is an application for initial licensure)

Name: _____

Physical Location of Facility: _____
(Street) (City)

(County) (State) (Zip Code)

Mailing Address:
(If different from above) _____
(Street) (City)

(County) (State) (Zip Code)

Telephone Number: _____

Email Address: _____
(Primary contact for correspondence)

Name of Executive Director: _____

Date facility began operating at current address: _____

Date facility began operating under current owner: _____

IV. Extension Locations:

Number of Extensions: _____

If there are no extensions, skip to next section. If reporting the name of each extension as part of the application for initial licensure or adding a new extension, please complete this section.

Name of Extension: _____

Physical Location of Extension: _____
(Street) (City)

(County) (State) (Zip Code)

Telephone number: _____

Extension Director's Name and Email Address: _____

NOTE: For more than one extension, please provide an attachment to this application with the name, location, telephone number, and extension director's name and email address.

V. CONTROL (Check one in each column.)

State	<input type="checkbox"/>	Profit	<input type="checkbox"/>	Individual	<input type="checkbox"/>
County	<input type="checkbox"/>	Nonprofit	<input type="checkbox"/>	Partnership	<input type="checkbox"/>
City	<input type="checkbox"/>			Corporation	<input type="checkbox"/>
Private	<input type="checkbox"/>				

VI. OWNERSHIP Name and address of direct owner

NOTE: Provide the following supporting documentation as an attachment to this application:

- The of name, mailing address, email address and phone number each person having at least a twenty-five (25) percent ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

VII. FIRE MARSHAL (FOR INITIAL, ADDITIONAL EXTENSIONS, AND CHANGE OF LOCATION APPLICATIONS.)

Please submit documentation of the Fire Marshal's approval for the location(s) where services will be provided. Final approval from the Fire Marshal shall be considered current if approved within 12 months from the date the Office of Inspector General receives the licensure application. If your facility has not been inspected and approved within the previous 12 months, please contact the Fire Marshal's Office to request an inspection.

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that any change in the information provided within this application which affects the licensure status of this service will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation allow state agency licensing personnel to enter the facility for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and I recognize that falsification of this application may result in denial or revocation of licensure.

Signature of Authorized Representative	Title	Date
--	-------	------

Submit the application, **fee***, **proof of accreditation****, and any attachments to:

Office of Inspector General
Division of Health Care
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

***For each extension location, add \$250 per extension to the starting fee, which is \$750 for initial licensure or change of ownership and \$500 for annual renewal.**

****Unless an extension is granted, Behavioral Health Services Organizations must become accredited within one (1) year of initial licensure by the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, or other nationally recognized accreditation organization. Proof of accreditation must be submitted annually for renewal of licensure.**

For Office Use Only: Check # _____ Amount _____
