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Application for License to Operate a Nonhospital-based Alcohol and Other Drug Treatment Entity (AODE)

December 2018 Edition

I. TYPE OF APPLICATION (Check all that apply.)

- ☐ Initial Licensure
- ☐ Annual Re-licensure
- ☐ Addition/Change in Service
- ☐ Change of Name
- ☐ Change of Location
- ☐ Change of Ownership

II. TYPE OF SERVICES (Check all that apply.)

- ☐ Outpatient Treatment
- ☐ Intensive Outpatient Treatment
- ☐ Partial Hospitalization
- ☐ Withdrawal Management Services
- ☐ Nonphysician-owned Office-based Opiate Treatment
- ☐ NTP Medication Station
- ☐ Residential Treatment
- ☐ Family Residential Treatment
- ☐ Residential Transitional Living
- ☐ Adolescent Residential
- ☐ Narcotic Treatment Program

III. IDENTIFICATION

License Number _____
(Insert "NA" if this application is for initial licensure)

Name of Facility _____

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)

Administrator Name _____

Date facility began operating at current address _____

Date facility began operating under current owner _____

IV. CONTROL (check one in each column)

- ◯ State
- ◯ County
- ◯ City
- ◯ Private
- ◯ Profit
- ◯ Nonprofit
- ◯ Individual
- ◯ Partnership
- ◯ Corporation

V. OWNERSHIP Name and address of direct owner

_____

_____

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

- The name, mailing address, email address, and phone number of each person or legal entity having an 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.

VI. OUTPATIENT AODE EXTENTION SITES (NOTE: Extension sites are not allowed for AODE residential programs, office-based opiate treatment programs, or narcotic treatment programs.)

A. Number of existing AODE outpatient extension sites, excluding primary location: _____

B. New extension site requested: ◯ Yes ◯ No

C. Location information: (If more than one outpatient extension location exists, provide the following information as an attachment to this application.)

Name of Extension Site _____

Physical Location _____
(Street) (City)

_____
(County) (State) (Zip Code)

Telephone number _____
(Include Area Code)

Administrator _____

VII. FIRE MARSHAL (Applicable at the time of initial licensure or a change of location.)

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 twelve (12) months from the date the Cabinet for Health and Family Services receives the licensure application. If your facility has not been inspected and approved within the previous twelve (12) months, please contact the Fire Marshal's Office to request an inspection.

VIII. NTP

Please attach all requested information listed below to application if applying for NTP. Failure to provide any requested information shall disqualify the application for further review.

- A copy of all information submitted for Substance Abuse and Mental Health Services Administration (SAMHSA) for certification to use opioid drugs in a treatment program.

- If the program is a corporation or partnership, the application shall list all partners' and members' names, addresses, and dates of birth.

- Attestation that each entity listed below was informed of the NTP's plan to open and operate, including the NTP's anticipated hours of operation and number of clients, and that the NTP and entity's leadership discussed coordination of services for their clients:
  - Hospitals;
  - Local law enforcement;
  - Local jails;
  - Community behavioral health and developmental and intellectual disability agencies;
  - Private, for-profit alcohol and drug services and publicly funded alcohol and drug services;
  - Department of Vocational Rehabilitation Services; and
  - Private, for-profit mental health counseling services.

  The attestation shall include the identity of the person(s) contacted at each entity and the date of the discussion.
- First-year budget including:
  - Available funds;
  - Pending funds;
  - Projected funds; and
  - Verification of funds.

- Schedule of the amount of the client fees.
- Program rules and instructions.
- Copies of all forms developed and used by the proposed NTP.

IX. MEDICATION STATION

An application to open a medication station must be submitted to the DEA, CSAT, and SNA at least ninety (90) days before a proposed opening.

A. Reason for Medication Station:
B. Site of Medication Station:
C. The proposed date of opening:
D. A description of any program changes that may occur with the relocation:

X. SIGNATURE OF AUTHORIZED REPRESENTATIVE

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 Cabinet for Health and Family Services until the facility is ready for an inspection.

I understand that as a condition precedent to initial licensure, this facility shall be in compliance with all state and federal statutes and administrative regulations applicable to the license requested.

I understand that **any change** in the information provided within this application affecting the licensure status of this facility or service will be reported to the Cabinet for Health and Family Services and **a new application** will be completed at that time. I agree that this facility and all aspects of its operation shall allow all state agency licensure personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application

is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

_____	_____	_____
Signature of Authorized Representative	Title	Date

Submit the application, fee, and any supportive documentation to:

CHFS Office of the Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

FEE AMOUNTS

The fee for initial and annual relicensure is $500.

The fee for each outpatient extension site is $80 per location.

The processing fee for a change of name is $25.

The processing fee for a change of location is $80.

The processing fee for a change of ownership is $500.

For Office Use Only: Check # _____ Amount _____