

Application for License to Operate a Chemical Dependency Treatment Service, Group Home, Psychiatric Residential Treatment Facility, or Residential Hospice Facility

OIG 002 – January 2017 Edition

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

- | | |
|--------------------------|---------------------|
| Provisional Licensure | Change of Name |
| Annual Re-licensure | Change of Location |
| Change in Number of beds | Change of Ownership |

II. TYPE OF FACILITY OR SERVICE

(Check the facility for which you are applying.)

- Chemical Dependency Treatment Service (CD)
- Group Home (GH)
- Psychiatric Residential Treatment Facility (PRTF)
- Residential Hospice (HOS)

III. NUMBER OF BEDS

NUMBER OF BEDS REQUESTED: _____

NUMBER OF BEDS CURRENTLY LICENSE AT THIS LOCATION: _____

IV. IDENTIFICATION

License Number _____
(Do not fill in License Number if this is an application for provisional licensure)

Name of Facility _____

Physical Location of Facility _____
(Street) (County)

(City) (State) (Zip Code)

Mailing Address (If different from above) _____
(Street) (County)

(City) (State) (Zip Code)

Telephone Number (Email of primary contact for correspondence)

Administrator Name _____

Date facility began operating at current address _____

Date facility began operating under current owner _____

V. CONTROL (Check one in each column.)

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

VI. OWNERSHIP Name and address of direct owner

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

- The of name, mailing address, email address and phone number each person or legal entity having an ownership interest in the facility or service;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation; or
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

VII. FIRE MARSHAL (APPLICABLE ONLY for PROVISIONAL LICENSURE and 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 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 as a condition precedent to provisional licensure, this facility/service 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 in within this application affecting the licensure status of this facility or 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/service 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
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Submit the application, fee and supportive documentation to:	Office of Inspector General 275 East Main Street, 5E-A Frankfort, Kentucky 40621
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For Office Use Only: Check # _____ Amount _____