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| *For BHA - Budget & Finance Use Only*  Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Received $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials \_\_\_\_\_\_\_\_\_\_\_  Date Application Materials Forwarded to DBHR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| *For DBHR Use Only*  Certification Number: |

State of Washington



Department of Social and Health Services

Behavioral Health Administration

### Division of Behavioral Health and Recovery

**INITIAL APPLICATION FOR BEHAVIORAL HEALTH AGENCY LICENSURE**

**AND**

**CERTIFICATION FOR MENTAL HEALTH, SUBSTANCE USE DISORDER,**

**AND/OR PROBLEM AND PATHOLOGICAL GAMBLING SERVICES**

**WAC 388-877-0305 AGENCY LICENSURE - APPLICATION**

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| **SECTION I: INITIAL APPLICATION FOR**  **BEHAVIORAL HEALTH AGENCY LICENSURE** |
| **Agency Ownership name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If your agency is a **public Agency,** please indicate the name of the tribal, federal, state, county, or municipal government, health district, or educational service district under which the agency will operate.  If your agency is a **corporation, partnership, or sole proprietor** **or other privately-owned agency**, please indicate the **entity or firm name** listed on your Washington State Master Business License (you must use this entity or firm name as your agency name.) |
|  |
| **Uniform Business Identification Number (UBI)**  Enter your Washington State Uniform Business Identification Number (UBI) (See [Chapter 70.60 RCW](http://www.ofm.wa.gov/policy/70.60.htm) )                    -                   - |
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| **AGENCY NAME, Line 1:** This is the name under which you provide certified services, and it will be listed in *Directory of Licensed and Certified Behavioral Health Agencies in Washington State (Directory). Note: The name of the agency must be the same as the* ***firm or registered trade name*** *and address listed on your Washington Business License.* |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **AGENCY NAME, Line 2 (IF ANY):** This name is published directly under the Agency Name in the *Directory.*  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Ownership Application Materials** |
| **All applicants must submit the following with this application:**  A copy of the report of findings from a criminal background check of any owner of 5 percent or more of the organizational assets.  A copy of the agency’s business license from the Department of Revenue that authorizes the organization to do business in  the state of Washington.  An application fee of $1,000. The fee amount must be in the form of a check or money order payable to the Department of Social  and Health Services (see address at the end of this form). |

***END OF SECTION I: INITIAL APPLICATION FOR BEHAVIORIAL HEALTH AGENCY LICENSURE***

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| **SECTION II: INITIAL APPLICATION FOR MAIN AGENCY**  **BEHAVIORAL HEALTH SERVICES CERTIFICATION** |
| **FUNDING SOURCE INFORMATION** |
| Is your agency BHO affiliated?  Yes  No |

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| **Please indicate the specific program service(s) for which your agency is seeking certification. For each service selected below, indicate if the service will receive public or private funding.** | | |
| **Chapter 388-877 WAC Outpatient Services** | | |
| ***(Check the box beside each specific program service for which your agency is seeking certification)*** | **Funding Source** | **Estimated Number of Service Hours First 12 Months**  **(For each service)** |
| Individual mental health treatment services (see WAC 388-877-0702) |  |  |
| Brief intervention mental health treatment services (see WAC 388-877-0704) |  |  |
| Group therapy mental health services (see WAC 388-877-0706) |  |  |
| Family therapy mental health services (see WAC 388-877-0708) |  |  |
| Rehabilitative case management mental health services (see WAC 388-877-0710) |  |  |
| Psychiatric medication and medication support mental health services  (see WAC 388-877-0712) |  |  |
| Day support mental health services (see WAC 388-877-0714) |  |  |
| Mental health services provided in a residential treatment facility  (see WAC 388-877-0716)  **Required to have Case Management, LRA or Conditional Release Support, and**  **Psychiatric Medication and Medication Support services with this service.** |  |  |
| Supported employment mental health services (see WAC 388-877-0720) |  |  |
| Supported employment SUD services (see WAC 388-877-0720) |  |  |
| Supportive housing mental health services (see WAC 388-877-0722) |  |  |
| Supportive housing SUD services (see WAC 388-877-0722) |  |  |
| Peer support mental health services (see WAC 388-877-0724) |  |  |
| Wraparound facilitation mental health services (see WAC 388-877-0726)  **Do you currently provide WISe services or plan on providing these services?**  **Yes  No** |  |  |
| Applied behavior analysis (ABA) mental health services (see WAC 388-877-0728) |  |  |
| Clubhouse mental health services (see WAC 388-877-0730) |  |  |
| SUD Level one outpatient services (see WAC 388-877-0738) |  |  |
| SUD Level two intensive outpatient services (see WAC 388-877-0740) |  |  |
| SUD Assessment only services (see WAC 388-877-0742) |  |  |
| SUD Alcohol and drug information school services (see WAC 388-877-0746) |  |  |
| SUD Information and crisis services (see WAC 388-877-0748) |  |  |
| SUD Emergency service patrol services (see WAC 388-877-0750) |  |  |
| SUD Screening and brief intervention services (see WAC 388-877-0752) |  |  |
| Problem and Pathological gambling treatment services (see WAC 388-877-0754) |  |  |
| **Chapter 388-877 WAC Involuntary and Court Ordered Outpatient Services** | | |
| ***(Check the box beside each specific program service for which your agency is seeking certification)*** | **Funding Source** | **Estimated Number of Service Hours First 12 Months**  **(For each service)** |
| Less restrictive alternative (LRA) or conditional release support mental health  services (see WAC 388-877-0805)  **Required to have Psychiatric Medication and Medication Support services with**  **this service.** |  |  |
| Emergency involuntary detention designated crisis responder (DCR) mental health  services (see WAC 388-877-0810) |  |  |
| Emergency involuntary detention designated crisis responder (DCR) SUD services  (see WAC 388-877-0810) |  |  |
| Driving under the influence (DUI) SUD assessment services  (see WAC 388-877-0820) |  |  |
| **Chapter 388-877 WAC Crisis Mental Health Services** | | |
| ***(Check the box beside each specific program service for which your agency is seeking certification)*** | **Funding Source** | **Estimated Number of Service Hours First 12 Months**  **(For each service)** |
| Crisis mental health telephone support services (see WAC 388-877-0905) |  |  |
| Crisis mental health outreach services (see WAC 388-877-0910) |  |  |
| Crisis mental health stabilization services (see WAC 388-877-(0915) |  |  |
| Crisis mental health peer support services (see WAC 388-877-0920) |  |  |
| **Chapter 388-877 WAC Opioid Treatment Program (OTP) Services** | | |
| ***(Check the box for the specific program service for which your agency is seeking certification)*** | **Funding Source** |  |
| Opioid treatment programs (OTP) (see WAC 388-877-1000) |  |  |

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| **Chapter 388-877 Withdrawal management,**  **residential substance use disorder treatment, and mental health inpatient services** |

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| ***(Check the box beside each specific program service for which your agency is seeking certification)*** | **Funding Source** | **Total Number of Beds**  **(For Each Service)** |
| Adult withdrawal management SUD services (see WAC 388-877-1100) |  |  |
| Youth withdrawal management SUD services (see WAC 388-877-1102) |  |  |
| Adult secure withdrawal management and stabilization SUD services  (see WAC 388-877-1104) |  |  |
| Youth secure withdrawal management and stabilization SUD services  (see WAC 388-877-1106) |  |  |
| Intensive inpatient SUD services (see WAC 388-877-1110) |  |  |
| Recovery house SUD services (see WAC 388-877-1112) |  |  |
| Long-term treatment SUD services (see WAC 388-877-1114) |  |  |
| Youth residential SUD services (see WAC 388-877-1116) |  |  |
| Adult evaluation and treatment mental health services (see WAC 388-877-1126) |  |  |
| Youth evaluation and treatment mental health services (see WAC 388-877-1128) |  |  |
| Child long-term inpatient program (CLIP) mental health services  (see WAC 388-877-1138) |  |  |
| Crisis stabilization unit mental health services (see WAC 388-877-1140) |  |  |
| Voluntary triage mental health services (see WAC 388-877-1144) |  |  |
| Involuntary triage mental health services (see WAC 388-877-1152) |  |  |
| Competency evaluation and restoration treatment mental health services  (see WAC 388-877-1154) |  |  |

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| **BEHAVIORAL HEALTH SERVICES CERTIFICATION**  **APPLICATION MATERIALS INCLUDED IN THIS APPLICATION** | | | | |
| **Please indicate which document(s) you are including by checking the applicable box** | | | | |
| **All applicants must submit:**  An electronic and/or hard copy of Administrative Policies and Procedures required by WAC 388-877, and Clinical Policies and  Procedures for each service for which you are applying for.  DBHR’s Policy and Procedure Review Tool for Providers found at <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies>, under the dropdown titled Technical Assistance Tools. | | | | |
| **If you are applying for Opiate Treatment Program (OTP) certification, you must submit:**  An OTP Addendum form (CS-21-A).  An OTP Community Relations Plan (CS-21-D).  Copies of these forms are available by contacting the Certification Policy Manager, Jodi Taylor at (360) 725-1456 or  [Jodi.Taylor@dshs.wa.gov](mailto:Jodi.Taylor@dshs.wa.gov), or by submitting a request in writing to: Certification Policy Manager, DSHS/DBHR, PO Box 45330,  Olympia, WA 98504-5330. | | | | |
| **If you are applying for detoxification or residential treatment services certification, you must submit (unless not required, e.g., your facility is on federal land or Veterans Administration affiliated):**  A copy of the residential treatment facility or hospital license issued by the Washington State Department of Health (DOH), Health  Systems Quality Assurance (HSQA) Office of Customer Services.  **License enclosed**  **License mailed at a later** **date** | | | | |
| **APPLICANT DECLARATIONS** | | | | |
| I declare the following: | | | | |
| * That I will notify DBHR if changes occur in any of the information provided in SECTIONS I and/or II of this application before licensure and certification is granted. | | | | |
| * That no person named in this application has had a license or certification for a treatment service or health care agency denied, revoked, or suspended. **WAC 388-877-0335 (1)(d)(i)** | | | | |
| * That no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse. **WAC 388-877-0335 (1)(d)(ii)** | | | | |
| * That no person or business entity named in this application is currently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in transactions involving certain federal funds. **WAC 388-877-0335 (1)(d)(xiii)** | | | | |
| * That no person or business entity named in this application is currently under investigation for or has committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180. **WAC 388-877-0335 (1)(d)(v).** | | | | |
| * That the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge. | | | | |
| Signature of Administrator or Legal Representative | | | | Date signed |
| Printed name of person signing form | | | | Title |
| Mailing address of person signing form  Street  City     State     Zip | | | | |
| Phone number of person signing form | | Fax number of person signing form | | |
| E-mail address of person signing form | | | | |
| **APPLICANT CONTACT INFORMATION**  Check here if same as above; if different, complete the information below | | | | |
| Applicant’s contact name | | | Title | |
| Mailing address  Street  City     State     Zip | | | | |
| Phone number | Fax number | | | |
| E-mail address | | | | |

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| **Privacy Notice**  This notice is provided in compliance with Governor’s Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this information to the Department of Social and Health Services, Division of Behavioral Health and Recovery (DBHR).  DBHR requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.  All information collected as a part of the certification process for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington (RCW) 42.56.230 through 290.  Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for as long as required by applicable law following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification.  Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.  **For more information:**   * DSHS public disclosure rules: [WAC 388-01](http://app.leg.wa.gov/WAC/default.aspx?cite=388-01&full=true) * DSHS public disclosure law: [RCW 42.56](http://app.leg.wa.gov/RCW/default.aspx?cite=42.56&full=true) * To Contact the DSHS Public Records/Privacy Officer: [DSHSPublicDisclosure@dshs.wa.gov](mailto:DSHSPublicDisclosure@dshs.wa.gov) |

***END OF SECTION II: INITIAL APPLICATION FOR MAIN AGENCY***

***BEHAVIORAL HEALTH SERVICES CERTIFICATION***

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| ***Check if you are including FACILITY AND PERSONNEL INFORMATION, SECTION III, with this application.***  ***Check if you plan to send FACILITY AND PERSONNEL INFORMATION, SECTION III, at a later date. Note: SECTION III of this application must be submitted, reviewed, and approved before licensing and certification can be granted.***  ***If checked, indicate the county in which you intend to provide the services:*** ***\_\_\_\_\_***  **PLEASE NOTE: DBHR will not begin processing incomplete applications. Insure that all required items in Sections I and II are included in your initial application if sending Section III at a later time. Incomplete applications will be returned.** |

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| **SECTION III: AGENCY FACILITY AND PERSONNEL INFORMATION** |

Check if you are sending SECTION III of this application separately at a later date than SECTIONS I and II.

Date SECTIONS I and II were sent: \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_

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| **AGENCY NAME (as indicated in SECTION I of this application)**  \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **FACILITY INFORMATION AND MATERIALS** | |
| **Facility Information** | |
| **Street Address** for the agency site to be licensed and listed in the *Directory* *of Licensed and Certified Behavioral Health Agencies in Washington State* | |
| **City**       **County**        **State**       **Zip Code** | |
| **Mailing Address** to be listed in the Directory. DBHR uses this address to send licensed agency information/documents.  **Check if same as street address** | |
| **City**       **State**       **Zip Code** | |
| **Agency Phone Number(s) to be listed in the *Directory.* List up to two numbers. You may add up to ten characters to add extension numbers or other information. See *Directory* for possible uses.**       \_\_\_\_\_\_\_ Check if toll-freeExtension number/Additional information \_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_ Check if toll-freeExtension number/Additional information \_\_\_\_\_\_\_\_\_\_\_\_ | **Fax Number to be listed in the *Directory of Certified Programs*:**       \_\_\_\_\_\_\_ |
| **Agency E-Mail Addresses** | |
| Administrator:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Clinical Supervisor:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Agency Customer Service:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Agency Website Address** | |
| Agency:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Facility Application Materials** | |
| **ALL APPLICANTS MUST SUBMIT THE FOLLOWING WITH SECTION III:**  A floor plan of the facility that shows the location where all behavioral health services are to be provided and the dimensions of  each room. See the sample floor plan provided with this application. The floor plan may be hand drawn. The reception area must be separate from all counseling and living areas.  A statement assuring the agency meets American Disability Act (ADA) standards and that the facility is appropriate for providing the proposed services. Please complete the Accessibility Barrier Checklist found on our website at  <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies>. | |
| **Residential** **APPLICANTS MUST SUBMIT a copy of the RTF or Hospital License issued by the Department of Health.**  License enclosed  License to follow at a later date (must be received before DBHR grants approval) | |
| **Non-Residential** **APPLICANTS MUST SUBMIT THE FOLLOWING WITH SECTION III:**  A completed Accessibility Barrier Checklist for the site to be certified. **Each element in the checklist must be marked** yes, no,  or not applicable (NA). Complete the corrective action plan section for any element marked “no.” Incomplete forms will be  returned. | |

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| **AGENCY PERSONNEL INFORMATION AND MATERIALS** | |
| **Administrator providing management or supervision of services** | |
| Name | Title |
| **Include with this application the following materials regarding the person named as administrator:**  Evidence that the administrator is appointed by the governing body, as required by WAC 388-877-0400(1) (a copy of a letter of  appointment signed by a member of the governing body or a governing body signature on the administrator’s job description).  A copy of the job description signed and dated by the appointed administrator that includes the new administrator’s commitment to  performing the key responsibilities listed in WAC 388-877-0400.  A copy of the report of findings from a Washington State Patrol criminal background check conducted within the last year, and a  copy of the report of findings of a criminal background check from the last state of residence if the person has lived out-of-state  within the past three years. | |
| **Mental Health Clinical Supervisor** | |
| Name (as listed on the current credential) | Title |
| **Substance Use Disorder Clinical Supervisor** | |
| Name (as listed on the current credential) | Title |
| **Problem and Pathological Gambling Clinical Supervisor** | |
| Name (as listed on the current credential) | Title |
| **Include the following materials regarding the person named as clinical supervisor:**  A copy of the job description signed and dated by the clinical supervisor and his or her supervisor.  A copy of the report of findings from a Washington State Patrol criminal background check conducted within the last year, and a  copy of the report of findings of a criminal background check from the last state of residence if the person has lived out-of-state  within the past three years.  **In addition for the Mental Health Clinical Supervisor:**  Documentation of 15 hours of training in clinical supervision approved by the Department of Health.  For Agency Affiliated Registrations, please also include a copy of MHP recognition and/or a copy of Master’s Degree and resume.  **In addition for the Substance Use Disorder Clinical Supervisor:**  Documentation of 28 hours of training in clinical supervision approved by the Department of Health.  **In addition for the Problem and Pathological Gambling Clinical Supervisor:**  Documentation of a valid international gambling counselor certification board-approved clinical consultant credential, a valid  Washington state certified gambling counselor II certification credential, or a valid national certified gambling counselor II  certification credential; and  Documentation of training on gambling-specific clinical supervision approved by a state, national, or international organization. | |
| **Additional Personnel Requirements for Substance Use Disorder Agencies** | |
| **Alcohol/Drug Information School (ADIS) Instructor** (if applying for ADIS certification) | |
| Name | Title |
| **Submit the following materials regarding the person named as ADIS Instructor with this form:**  A copy of the job description signed and dated by the person named and the person’s supervisor.  If the ADIS Instructor is not a CDP, a copy of an Alcohol/Drug Information School Instructor Certificate issued by a community college approved by the Washington State Division of Behavioral Health and Recovery. | |
| **Agency Accreditation Information** | |
| **Is your agency accredited?**  Yes  No  **If yes, check the organization that accredits your agency:**  Commission on Accreditation of Rehabilitation Facilities (CARF)  Council on Accreditation (COA)  The Joint Commission  Washington State Division of Behavioral Health and Recovery (DBHR). (Opiate Treatment Programs only.)  **Do you want your accreditation listed in the Directory?**  Yes. (If yes, attach a copy of your current accreditation certificate.)  No  **Do you want to be contacted about becoming a “deemed agency” under WAC 388-877-0310?**  Yes  No | |

**Please send SECTIONS I, II, and III of the completed application, required application materials, and the $1,000.00 application fee by check or money order payable to Department of Social and Health Services to:**

**If sending by US Postal Service: For UPS or FedEx Delivery:**

BHA - Budget & Finance BHA - Budget & Finance

Department of Social & Health Services Department of Social & Health Services

PO Box 45525 Blake Office Park East

Olympia, WA 98504 4450 10th Ave SE

Lacey, WA 98503

**If sending SECTION III later than SECTIONS I and II, please send SECTION III directly to: Provider Request Manager, Division of Behavioral Health and Recovery, PO Box 45330, Olympia, WA 98504-5330, or by email to:** [**dbhrproviderrequests@dshs.wa.gov**](mailto:dbhrproviderrequests@dshs.wa.gov)**.**

**If you have questions about this form or its requirements, contact the Provider Requests Manager at the above email address.**