Rhode Island Behavioral Healthcare, Developmental Disabilities and Hospitals
Office of Facilities and Program Standards and Licensure
14 Harrington Road, Cranston, Rhode Island 02920
Phone # 462-2317 Fax # 462-0393

APPLICATION FOR INITIAL LICENSURE TO PROVIDE BEHAVIORAL HEALTHCARE SERVICES

DATE:_____

License # (for Licensing Office use only): _____

PART I Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide services:

Name of Organization:

Mailing Address:

City:_____State:_____ Zip Code:_____

Telephone:_____ Fax:_____ FEIN:_____

Chief Executive Officer or Director: Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant:

Name:_____ Title:_____

Telephone Number:_____ Fax Number:_____ Email Address:_____

Website (if Applicable):_____

PART II Organizational Structure: Identify the organizational structure of the applicant's governing body:

Type of Ownership: (Check One): Individual:_____ Partnership:_____ Corporation:_____

Other (Specify)

Check One: For Profit:_____ Non-Profit:_____

Is the Organization Incorporated: Yes:_____No:_____

Do you have an Advisory Committee? Yes:_____No:_____If yes, attach list of names

Is the organization licensed, certified or accredited by any other authority? Yes:__No:___

If yes, list authority and type of license, accreditation or certification:

Has any application for a license, certification or accreditation ever been denied? Yes:__No:___

If yes, explain:

Do you wish to be granted deemed status for the annually designated standards? Yes:___ No:___

If yes, please attach a copy of the most recent accreditation report.

If no, and your organization is accredited, please attach an explanation specifying the reason(s).

Part III Selected Services Information: Use the list below to designate the behavioral healthcare services that you wish to provide.

1. General Outpatient Services
2. Integrated Dual Diagnosis Treatment
3. Medication Services and Laboratory Services
4. Case Management Services
5. Community Psychiatric Supportive Treatment
6. Intensive Outpatient Services
7. Community Integration Services
8. Supported Housing Services
9. Residential Services
10. Outpatient Detoxification Services
11. Medical Detoxification Services
12. Opioid Treatment Programs

PART IV - Narrative

1. Describe basic program: Mission statement, treatment modalities, program components, etc.
2. Describe the proposed financial plan.
3. Describe staffing, including number and types of each position, (including federally-funded positions) and consultants hired or utilized.
4. If your program utilizes volunteer services, describe how the volunteers are utilized.
5. Attach written job descriptions for each position.
6. Describe your organization's staff training program.
7. Describe daily program schedule, including hours of operation and, (if available) emergency services.
8. Describe your program's discharge criteria for both completion of treatment and for dismissal from treatment.
9. Describe your program's process for follow-up of terminated clients. If there is no process, give explanation.

Complete for each service type to be offered at each specific site by the organization. (see Part III). (Please copy additional sheets as needed)

Location Name:_____License # (for Licensing Office use only):_____

Address:

City:_____ State:_____ Zip:_____ Telephone Number:

Selected Service Type:_____ (If Residential Program) Client Capacity:_____

Name and Address of Owner:_____

Type of Building(s): Apartment__ Condominium__ Single Family__ Duplex__ Multi-Family__

Type of structure:_____Wood frame _____ Masonry _____ Metal_____

Number of Stories:____ Number of Rooms:_____Type of Zoning:_____

Does building have a fire sprinkler system? Yes: ___ No:___

Is building fire alarm connected to local fire department? Yes: ___ No:___

Date and Results of last State Fire Marshal Survey:_____

If rented or leased, is owner willing to allow any necessary repairs or renovations to be made to the building to meet necessary life-safety requirements? Yes: ___ No:___

If No, what is your alternative plan?_____

Does the building comply with all applicable federal, state and local laws, codes, rules and regulations relative to health, accessibility, fire safety, building, minimal housing and zoning? Yes:___ No:___

Location Name:_____License # (for Licensing Office use only):

Address:

City:_____ State:_____ Zip:_____ Telephone Number:

Selected Service Type:

(If Residential Program) Client Capacity:_____

Name and Address of Owner:_____

Type of Building(s): Apartment__ Condominium__ Single Family__ Duplex__ Multi-Family__

Type of structure:_____Wood frame _____ Masonry _____ Metal _____

Number of Stories:____ Number of Rooms:_____Type of Zoning:_____

Does building have a fire sprinkler system? Yes: _____ No:_____

Is building fire alarm connected to local fire department? Yes: _____ No:_____

Date and Results of last State Fire Marshal Survey:_____

If rented or leased, is owner willing to allow any necessary repairs or renovations to be made to the building to meet necessary life-safety requirements? Yes: _____ No:___

If No, what is your alternative plan?_____

Does the building comply with all applicable federal, state and local laws, codes, rules and regulations relative to health, accessibility, fire safety, building, minimal housing and zoning? Yes:___ No:___

PART V Additional Required Information

1. Attach a notarized listing of the names, addresses of all owners, officers, and directors, whether individual, partnership, or corporation, with percentages of ownership designated.
2. Attach evidence of compliance with the requirements for licensure stated in Section 4.0, Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Mental Health, Retardation and Hospitals.
3. **Opiate Treatment Programs Only:** attach evidence of compliance with the requirements for licensure stated in Section 3.2.4, Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Mental Health, Retardation and Hospitals.

PART VI

In applying for deemed status I understand and acknowledge that sections of the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations are deemed solely at the discretion of the Department. I agree and acknowledge that denials or revocations of all or part of deemed status by the Department are neither subject to appeal nor review.

I am aware that authorized representatives of the Licensing Agency have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility for which an application has been received or for which a license has been issued. This application shall constitute permission for and willingness to comply with such inspections.

I am aware of the statutory authority of the Department as contained in chapter 40.1 of the Rhode Island General Laws, and of the standards, rules and regulations prescribed thereunder, which regulate the operation of behavioral healthcare treatment facilities and programs.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant:_____ Date:_____

Title:_____

If you have any questions concerning the application, please contact this office at (401) 462-6049.

This application is to be returned within 30 days to:

ADMINISTRATOR OF LICENSING
OFFICE OF FACILITIES AND PROGRAM STANDARDS AND LICENSURE
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES AND HOSPITALS
BARRY HALL
14 HARRINGTON ROAD
CRANSTON, RHODE ISLAND 02920