

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

INITIAL PROVIDER APPLICATION FOR LICENSING
Code of Virginia §37.1-183.1



Please use a typewriter or print legibly using permanent, black ink. The chief executive officer, director, or other member of the governing body who has the authority and responsibility for maintaining standards, policies, and procedures for the service may complete this application.

1. APPLICANT INFORMATION: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization Name: _____

Mailing Address _____

City: _____ County _____ State: _____

Zip: _____ Phone:() _____ Email: _____

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: _____

Phone:() _____ Fax Number:() _____ E-mail: _____

Children Residential Service Only: (The liaison is the staff that shall be responsible for facilitating cooperative relationship with neighbors, the school system, local law enforcement, local government officials and the community at large.)

Community Liaison Name: _____ Phone () _____ E-mail _____

2. ORGANIZATIONAL STRUCTURE: Identify the organizational structure of the applicant's governing body.

Check one(1) of the following:

[] Non-Profit [] For-Profit

Check one(1) of the following:

[] Individual (proprietorship) [] Partnership
[] Corporation [] Unincorporated Organization or Association

Public agency:

[] State [] Community Services Board [] Other

Identify accrediting or certifying organization from the following:

[] Accreditation Council for Services for People with Developmental Disabilities [] Virginia Association of Special Education Facilities
[] Joint Commission on Accreditation of Health Care Organizations [] Other association or organization:
[] Commission on Accreditation of Rehabilitation Facilities _____

3. APPLICANT PARENT COMPANY INFORMATION: Identify the parent company of person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Company Name: _____

Mailing Address: _____ City: _____ County: _____ State: _____

Zip: _____ Phone:() _____ E-mail: _____

Name: _____ Title: _____

4. SERVICE TYPE:

Place a check to identify the service type. If the service type is not listed, please note in the service information section. Please note new applicants (no independent service operation experience) are permitted to apply for **ONE** service on the initial application.

* **RESIDENTIAL SERVICES**

- Community ICF-ID (MR)
- Community Gero-psychiatric
- Crisis Stabilization
- Group Home
- Half-Way House
- Medical Detox and Social Detox
- Residential Community Services
- Residential Respite
- Residential Treatment
- Residential Treatment SA women w/children
- Supervised Living

* **DAY SUPPORT SERVICES**

- Clubhouse
- Day Support
- Day Treatment
- Intensive Outpatient
- Partial Hospitalization/Ambulatory Detox
- Psychosocial Rehabilitation
- Therapeutic After-School
- Center-Based Respite

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SUPPORTED IN-HOME SERVICES

- In-Home Services
- In-Home and out-of home Respite
- Mental Health Community Support Services
- Crisis Stabilization

* **CASE MANAGEMENT SERVICES**

* **INPATIENT SERVICES**

- Psychiatric Unit
- Medical Detox/CD Unit

* **INTENSIVE IN-HOME SERVICES**

* **OPIOID TREATMENT SERVICES**

* **OUTPATIENT SERVICES**

- Outpatient
- Emergency

* **SPONSORED RESIDENTIAL HOME SERVICES**

* **DEPARTMENT OF CORRECTIONS FACILITIES SERVICES**

* **INTENSIVE COMMUNITY SERVICES (ICT)**

* **PROGRAMS FOR ASSERTIVE COMMUNITY TREATMENT (PACT)**

* **CHILDREN'S RESIDENTIAL SERVICE (include the \$500.00 nonrefundable application fee for this service only)**

- | | |
|--|---|
| <input type="checkbox"/> Facility for Mentally III/Emotionally Disturbed (MED) | <input type="checkbox"/> Children's Crisis Stabilization |
| <input type="checkbox"/> Facility for Intellectually Disabled (ID) | <input type="checkbox"/> Children's Independent Living Program |
| <input type="checkbox"/> Facility for Substance Abuse (SA) | <input type="checkbox"/> Children's Residential Respite Care Facility |

5. SERVICE INFORMATION: Complete for the service type proposed by the organization to be licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services. (See listing of services types on previous page.)

Service Type: _____ **Service Director:** _____

Phone: () _____ **E-mail:** _____

THIS SERVICE SERVES:

Individuals with **SINGLE** diagnosis (check all that apply): **AND/OR** Individuals with **MULTIPLE** diagnoses (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Intellectual Disability (MR) | <input type="checkbox"/> Intellectual Disability/Mental Illness |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Intellectual Disability/Substance Abuse |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Mental Illness/Substance Abuse |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Mental Illness/Intellectual Disability/Substance Abuse |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Developmental Disability/Other Diagnosis _____ |
| | <input type="checkbox"/> Brain Injury/Other Diagnosis _____ |

Client Demographics (check all that apply):

Male Female Child Adolescent (Min. & Max. Age Range) _____ Adult Geriatric

Accreditation/Certification by: _____

LOCATION

6. Location Name: _____ # of beds: _____

Address: _____

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City: _____ County _____ State: _____ Zip: _____

Location Manager: _____ Phone:() _____ E-mail: _____

Directions: _____

7. NAME AND ADDRESS OF OWNER OF PHYSICAL PLANT

Name	
Address	

8. RECORDS: IDENTIFY THE LOCATION OF THE FOLLOWING RECORDS

Financial Records	Address: _____ City: _____ County _____ State: _____ Zip: _____
Personnel Records	Address: _____ City: _____ County _____ State: _____ Zip: _____
Residents' Records	Address: _____ City: _____ County _____ State: _____ Zip: _____

<u>REQUIRED ATTACHMENTS</u>	<i>Children's Residential Service Reg</i>	<i>All Other Services Reg.</i>
1. <input type="checkbox"/> This completed Application	§42-11-30(A)	
2. <input type="checkbox"/> Resumes of all Identified Staff	§42-11-30(A)	§35-105-420(A)
3. <input type="checkbox"/> Working Budget (appropriated revenues and projected expenses for one year)	§42-11-30(A)(1)	§35-105-40(A)(1)
4. <input type="checkbox"/> Position Descriptions	§22 VAC 42-11-280, §22 VAC 42-11-340(A), §22 VAC 42-11-35(A), §22 VAC 42-11-360(A), §22 VAC 42-11-370(A), §22 VAC 42-11-380(A) & §22 VAC 42-11-770	§35-105-40 & §410(A)
5. <input type="checkbox"/> Records Management Policy	§22 VAC 42-11-640, §12 VAC 35-115-80-(B)(2), §12 VAC 35-45-110, §12 VAC 35-45-120	§35-105-40 & §870(A)
6. <input type="checkbox"/> Complete Service Description (including philosophy and objectives of the organization, comprehensive description of population to be served, and services to be offered, brochures, pamphlets distributed to the public, etc)	§42-11-630(A), §12 VAC 35-45.70(B) §42-11-780(A), §12 VAC 35-45-80(B)	§35-105-40 & §580(C)
7. <input type="checkbox"/> Evidence of Financial Resources to Operate the Budget for Ninety Days (an ongoing basis)	§42-11-30(A)(1)	§35-105-210(A)
8. <input type="checkbox"/> A copy of the Organizational Structure	§42-11-30(A)(1)	§35-105-190(B)
9. <input type="checkbox"/> Certificate of Occupancy (except home-based services)	§42-11-30(A)(1)	§35-105-260
10. <input type="checkbox"/> Evidence of authority to conduct Business in Virginia,	§42-11-30(A)(1)	§35-105-40(A)(3)
11. <input type="checkbox"/> Staffing schedule & written staffing plan (list of staff members with designated positions, qualifications, etc.)	§42-11-320 & §42-11-830	§35-105-590
<i>And for residential services:</i>		
12. <input type="checkbox"/> Copy of the Building floor plan, with dimensions	§42-11-30(A)(1)	§35-105-40 (B)(5)
13. <input type="checkbox"/> Current Health Inspection	§42-11-30(A)(1)	§35-105-290
14. <input type="checkbox"/> Fire Inspection, if over eight residents	§42-11-420, §42-11-30(A)(1), & §13 VAC 5-51 et seq.	§35-105-320
Children's Residential Service Only		
15. <input type="checkbox"/> Articles of Incorporation, By- laws, & Certificate of Incorporation	§42-11-30(A)(1)	Facility operated by a <u>VA</u> corporation
16. <input type="checkbox"/> Articles of Incorporation, By- laws, & Certificate of Authority	§42-11-30(A)(1)	Facility operated by a <u>out of state</u> corporation
17. <input type="checkbox"/> Listing of board members, the Executive Committee, or public agency all members of legally accountable governing body	§42-11-30(A)(1)	Facilities with a Governing Board
18. <input type="checkbox"/> References for three officers of the Board including President, Secretary and Member-at-Large	§42-11-30(A)(1)	Facility operated by Corp., an unincorporated Organization, or an Association

Certificate of Application

This certificate is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance if licensed.

I grant permission to authorized agents of the Department of Mental Health, Mental Retardation and Substance Abuse Services to make necessary investigations into this application or complaints received.

I understand that unannounced visits will be made to determine continued compliance with regulations.

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: _____ Title: _____ Date: _____

If you have any questions concerning the application, please contact this office at (804) 786-1747. This application is to be returned to:

**Office of Licensing,
Department of Mental Health, Mental Retardation and Substance Abuse Services,
Post Office Box 1797, Richmond, Virginia 23218-1797**