



**Virginia Department of Mental Health, Mental Retardation,
and Substance Abuse Services**
RENEWAL PROVIDER APPLICATION FOR LICENSING

SECTION 1: Applicant Renewal 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: () _____

CEO or CAO: _____ Phone: () _____

Fax Number: () _____ Email: _____

****Please review the "licensed as" statement for accuracy in the descriptions of services. If any are inconsistent with the actual service, please note the discrepancy on the license.**

Section 2: Service Renewal Information: Please list the license numbers you are applying for renewal:

- | | |
|--------------------------|---------------------------|
| 1. _____ - _____ - _____ | 9. _____ - _____ - _____ |
| 2. _____ - _____ - _____ | 10. _____ - _____ - _____ |
| 3. _____ - _____ - _____ | 11. _____ - _____ - _____ |
| 4. _____ - _____ - _____ | 12. _____ - _____ - _____ |
| 5. _____ - _____ - _____ | 13. _____ - _____ - _____ |
| 6. _____ - _____ - _____ | 14. _____ - _____ - _____ |
| 7. _____ - _____ - _____ | 15. _____ - _____ - _____ |
| 8. _____ - _____ - _____ | 16. _____ - _____ - _____ |

SECTION 3: Service Close Information: Please list the license numbers you are choosing NOT TO RENEW and are surrendering:

- | | |
|--------------------------|--------------------------|
| 1. _____ - _____ - _____ | 4. _____ - _____ - _____ |
| 2. _____ - _____ - _____ | 5. _____ - _____ - _____ |
| 3. _____ - _____ - _____ | 6. _____ - _____ - _____ |

SECTION 4: Service Change Information: PLEASE LIST CHANGES ONLY:

1. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone:** () _____
Fax Number: _____ **Location E-mail:** _____
Directions: _____

2. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone:** () _____
Fax Number: _____ **Location Email:** _____
Directions: _____

3. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone:** () _____
Fax Number: _____ **Location Email:** _____
Directions: _____

4. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone:** () _____
Fax Number: _____ **Location Email:** _____
Directions: _____

5. **Location Name:** _____ **License #:** _____ **# of beds:** _____
Address: _____
City: _____ **County** _____ **State:** _____ **Zip:** _____
Location Manager: _____ **Phone:** () _____
Fax Number: _____ **Location Email:** _____
Directions: _____

Note: If there are additional locations please photocopy additional sheets as needed.

SECTION 5. Certificate of Application

This Certificate of Application 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.

IT IS MY INTENT TO: (a) COMPLY WITH ALL APPLICABLE STATUES AND (b) TO MAINTAIN COMPLIANCE WITH ALL APPLICABLE REGULATIONS

PROVIDERS OF CHILDREN’S RESIDENTIAL SERVICES MUST SUBMIT WITH THE APPLICATION A \$100.00 RENEWAL FEE. BUSINESS CHECK OR MONEY ORDER MADE PAYABLE TO THE TREASURER OF VIRGINIA. PERSONAL CHECKS NOT ACCEPTED.

Signature of Applicant: _____ Date: _____

Title: _____

If you have any questions concerning the application, please contact this office at (804) 786-1747. This application is to be returned within 30 days to:

**The Office of Licensing
Department of Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797
Website: <http://www@dmhmrsas.virginia.gov>**