



Health Standards Section
License Application
Behavioral Health Service Provider

Section 1: PROVIDER INFORMATION

☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION ☐ OTHER (Specify) _____

LICENSE NUMBER _____ EXPIRATION DATE _____

*Check & Payment Transmittal Form must be submitted to LDH Licensing Fee, PO Box 734350, Dallas, TX 75373

TOTAL FEE AMOUNT INCLUDED _____ CHECK / MONEY ORDER # _____

STATE ID #BH _____

FACILITY (DBA) NAME _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ FAX NUMBER (____) _____ EMAIL ADDRESS _____
(not voicemail)

*MAILING ADDRESS (IF DIFFERENT) _____

CITY / STATE / ZIP _____

HOURS OF OPERATION _____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

ADMINISTRATOR _____ Email _____

CLINICAL DIRECTOR See §5643 (B)(2)) _____

MEDICAL DIRECTOR _____

Is this facility located on the campus or in the building of another healthcare facility?

☐ No ☐ Yes If yes, list the name and state ID# of the other healthcare facility: _____

Accredited? ☐ No ☐ Yes: Accrediting organization: _____ Expiration date: _____

If "YES" you may request for "deemed" status in writing post licensure approval (refer to the regulations)

Section 2: TYPE OF FACILITY/PROVIDER

TYPE OF SERVICE: ☐ Substance Abuse/Addiction only* ☐ Mental Health only ☐ Both*

*if checked, who is the Addictionologist? _____ See §5693.

POPULATION SERVED: ☐ Adults (18+) ☐ Adolescent (13-17yo) ☐ Children (under13)

BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

TYPE of facility and TREATMENT PROGRAMS: If you indicate you provide services in section C, you may not select services in sections A and B.

☐ **A) RESIDENTIAL FACILITY** (substance abuse/addiction treatment programs only)

- ☐ Clinically Managed Low-Intensity Residential Treatment Program (Halfway House) (ASAM Level III.1)
- ☐ Clinically Managed Medium-Intensity Residential Treatment Program (adult only ASAM Level III.3)
- ☐ Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)
- ☐ Clinically Managed Residential Detoxification Program (Social Detoxification ASAM Level III.2D)
- ☐ Medically Monitored Intensive Residential Treatment Program (adult only ASAM Level III.7)
- ☐ Medically Managed Residential Detoxification (Medically Supported Detoxification- adult only- ASAM Level III.7D)
- ☐ Mothers with Dependent Children Program (Dependent Care Program)

NUMBER OF LICENSED UNITS (Bedrooms) _____

NUMBER OF LICENSED BEDS _____

☐ **B) OUTPATIENT FACILITY**

- ☐ Mental Health Services Program/Clinic
- ☐ Psychosocial Rehabilitation Services Program
- ☐ Crisis Intervention Program
- ☐ Community Psychiatric Support and Treatment Program
- ☐ Addiction Outpatient Treatment Program (ASAM Level I)
- ☐ Ambulatory Detoxification with Extended on-site monitoring Program (ASAM Level II-D)
- ☐ Intensive Outpatient Treatment Program (ASAM Level II.1)
- ☐ Partial Hospitalization (ASAM Level II.5) See §5698
- ☐ Opioid Treatment Program (if approved by SOTA)

☐ **C) HOME and/or COMMUNITY SERVICES PROGRAM** (seen in the home and/or community only; never in the office)

- ☐ Psychosocial Rehabilitation Services Program
- ☐ Crisis Intervention Program
- ☐ Community Psychiatric Support and Treatment Program

Section 3: TYPE OF OWNERSHIP

NON- PROFIT

- ☐ INDIVIDUAL/SOLE PROPRIETOR
- ☐ CORPORATION ☐ LLC
- ☐ PARTNERSHIP
- ☐ RELIGIOUS AFFILIATION
- ☐ UNINCORPORATED ASSOCIATION
- ☐ OTHER (Specify): _____

FOR – PROFIT

- ☐ INDIVIDUAL/SOLE PROPRIETOR
- ☐ CORPORATION ☐ RELIGIOUS AFFILIATION
- ☐ PARTNERSHIP
- ☐ GROUP PRACTICE ☐ UNINCORPORATED ASSOCIATION
- ☐ LLC
- ☐ OTHER (Specify): _____

GOVERNMENT

- ☐ FEDERAL ☐ HUMAN SVCS DISTRICT/ AUTHORITY
- ☐ CITY
- ☐ CITY/PARISH
- ☐ HOSPITAL DISTRICT
- ☐ COMBINATION GOV-N-PROFIT
- ☐ OTHER (Specify) _____

BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

LEGAL ENTITY / CORPORATION NAME _____ EIN# _____

ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (_____) _____ FAX NUMBER (_____) _____

If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	ADDRESS	TELEPHONE NUMBER

Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ Yes ☐ No
 (Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other providers.

Owner	Facility Name	Facility Address	Provider #, LIC. #, or State ID#

Has there been a change of ownership or control within the last year? ☐ Yes ☐ No If yes, give date: _____**Section 4: OFF-SITE INFORMATION** (attach addendum A's for each offsite listed below)

INDICATE THE NAME, ADDRESS, CITY, STATE, ZIP, PARISH, AND TELEPHONE NUMBER OF EACH OFF-SITE CAMPUS

OFF-SITE NAME	GEOGRAPHICAL ADDRESS (Street, City, State, & Zip Code)	PARISH	TELEPHONE NUMBER	LICENSE NUMBER
1.				
2.				
3.				
4.				

Section 5: ATTESTATION & SIGNATURE**ATTESTATION** (Read carefully):

I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Emergency Preparedness Attestation: I certify that I am in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning emergency preparedness.

Opioid Treatment Attestation: I certify that the facility is in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning treatment for opioid use disorders.

AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)_____
AUTHORIZED REPRESENTATIVE SIGNATURE_____
DATE

BEHAVIORAL HEALTH SERVICE PROVIDER LICENSE APPLICATION

OFF-SITE ADDENDUM A

OFF-SITE NAME	LICENSE #	ADDRESS OF OFFSITE	PARISH	TELEPHONE NUMBER

*****See §5605. (G.) regarding Off-Sites *****

TYPE of facility and TREATMENT PROGRAMS:

- ☐ **A) INPATIENT / RESIDENTIAL FACILITY** (substance abuse/addiction treatment programs only)
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 - ☐ Clinically Managed Medium-Intensity Residential Treatment Program (adult only ASAM Level III.3)
 - ☐ Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)
 - ☐ Clinically Managed Residential Detoxification Program (Social Detoxification ASAM Level III.2D)
 - ☐ Medically Monitored Intensive Residential Treatment Program (adult only ASAM Level III.7)
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- ☐ Community Psychiatric Support and Treatment Program
- ☐ Addiction Outpatient Treatment Program (ASAM Level I)
- ☐ Ambulatory Detoxification with Extended on-site monitoring Program (ASAM Level II-D)
- ☐ Intensive Outpatient Treatment Program (ASAM Level II.1)
- ☐ Partial Hospitalization (ASAM Level II.5) See §5698
- ☐ Opioid Treatment Program (if approved by SOTA)

☐ **C) HOME and/or COMMUNITY SERVICES PROGRAM** (seen in the home and/or community only; never in the office)

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Make copies of this addendum as needed for each offsite