LOUISIANA DEPARTMENT OF HEALTH
Health Standards Section

Behavioral Health Service Provider License Application

Section 1: Provider Information

☐ Renewal ☐ Initial ☐ Other	License Number	Expiration
Check/Money Order Number:	Check Amount:	
**Check & Payment Transmittal Form must be submitted to* DHH Licensing Payments, P.O. Box 734350, Dallas, TX 75373-4350		
☐ **Check if any change has occurred since last application**	**State ID#: BH**	
Facility (DBA) Name		
Geographical Address		
Parish	**Email**	
Mailing Address *(if different)*		
Telephone *(not voicemail)*	**Fax**	
Administrator	**Email**	
Clinical Director *[see §5643 (B)(2)]*	**Medical Director**	
Days of Operation ☐ **Mo** ☐ **Tu** ☐ **We** ☐ **Th** ☐ **Fr** ☐ **Sa** ☐ **Su**	**Hours of Operation** **a.m.** *to* **p.m.**	
Is the Facility located on the campus or in the building of another Facility/Provider? ☐ **No** ☐ **Yes** If yes, list the name of the Host Facility/Provider:		
Accrediting Organization *(if applicable)*: *If "YES" you may request for "deemed" status in writing post licensure approval (refer to the regulations)*	**Accreditation Expiration:**	

Section 2: Type of Facility

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)*

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/addition treatment programs only)***

- ☐ Clinically Managed Low-Intensity Residential Treatment (ASAM Level 3.1)
- ☐ Clinically Managed Medium-Intensity Residential Treatment (ASAM Level 3.5)(adolescents)
- ☐ Clinically Managed High-Intensity Residential Treatment (ASAM Level 3.5)(adults)
- ☐ Medically Managed Residential Treatment (ASAM Level 3.7)
- ☐ Medically Managed Residential Withdrawal Management (ASAM Level 3.7-*WM*)
- ☐
- ☐

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
- ☐ Mental Health Intensive Outpatient Programs *(MHIOPs)*
- ☐ Addiction Outpatient Treatment (ASAM Level 1.5)
- ☐ Intensive Outpatient Treatment (ASAM Level 2.1)
- ☐ High Intensity Outpatient Treatment (ASAM Level 2.5)
- ☐ Medically Managed Intensive Outpatient Treatment (ASAM Level 2.7)
- ☐ Opioid Treatment Program (if approved by SOTA)
- ☐ Mobile Crisis Response

☐ **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

Are you an approved Opioid Treatment Program (Methadone)?	☐ Yes ☐ No ☐ N/A
Do you provide Opioid treatment (Methadone) to pregnant women? **If **yes**, how many have been treated in the last year?*	☐ Yes* ☐ No ☐ N/A
Do you provide Medication Assisted Opioid Treatment (MAT)?	☐ Yes ☐ No ☐ N/A
Do you provide Medication Assisted Opioid Treatment (MAT) to pregnant women? **If **yes**, how many have been treated in the last year?*	☐ Yes* ☐ No ☐ N/A
Are you in compliance with Act Number 309?	☐ Yes ☐ No ☐ N/A
If not, are you working toward compliance with Act Number 309? **If **yes or no**, please describe:*	☐ Yes* ☐ No* ☐ N/A

Section 3: Ownership

Legal Entity/Corporation Name

Address

Telephone	**Fax**

EIN #

Has there been a change of ownership or control within the last year?
☐ **Yes*** ☐ **No** ***If ***yes***, give date:*

If the disclosing entity is a corporation, list name, address, and telephone number of the President.
☐ *Not applicable*

Chief Officer's Name	**Chief Officer's Address**	**Chief Officer's Telephone #**

Are any owners of the disclosing entity also owners of other licensed health care facilities? (Proprietorship, Partnership or Board Member)
☐ **Yes*** ☐ **No** ***If ***yes***, provide information requested for each.*

Owner	**Facility Name**	**Facility Address**	**Provider#/License#/ State ID#**

Section 4: Type of Ownership

Non-Profit	For Profit	Government
☐ Individual/Sole Proprietor	☐ Individual/Sole Proprietor	☐ Federal Facility
☐ Corporation	☐ Corporation	☐ Service District
☐ Limited Liability Company	☐ Limited Liability Company	☐ State Facility
☐ Partnership	☐ Partnership	☐ Combination Gov-N-Profit
☐ Religious Affiliation	☐ Group Practice	☐ Parish *(specify)*
☐ Unincorporated Association	☐ Other:	☐ Other:
☐ Other:		

Section 5: Off-Site Information

(attach addendum **A's** for each offsite listed below)

*A Behavioral Health Service Provider may operate within a 50 mile radius of **ONE designated offsite location.** Select **ONE** offsite within 50 miles of the main location with an "X" **ACT No.625**

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	WITHIN 50 MILES	TELEPHONE NUMBER	LICENSE NUMBER
1.			☐		
2.			☐		
3.			☐		
4.			☐		

Section 6: Attestation & Signature (READ CAREFULLY)

Licensure Attestation: 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 Louisiana Department of Health, 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 Louisiana Department of Health.

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.

Authorized Representative's Printed Name & Title:

Authorized Representative's Signature:	**Date:**

Off-Site Addendum A

OFF-SITE NAME	GEOGRAPHICAL ADDRESS *(Street, City, State, & Zip Code)*	PARISH	TELEPHONE NUMBER	LICENSE NUMBER

TYPE of facility and TREATMENT PROGRAMS:
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- ☐ Clinically Managed High-Intensity Residential Treatment (ASAM Level 3.5) (adults)
- ☐ Medically Managed Residential Treatment(ASAM Level 3.7)
- ☐ Medically Managed Residential Withdrawal Management (ASAM Level 3.7 – WM)
- ☐
- ☐

Number of licensed units *(Bedrooms)*	**Number of licensed beds**

☐ **B) OUTPATIENT FACILITY**

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- ☐ Psychosocial Rehabilitation Services Program
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- ☐ Mental Health Intensive Outpatient Programs *(MHIOPs)*
- ☐ Addiction Outpatient Treatment (ASAM Level 1.5)
- ☐ Intensive Outpatient Treatment (ASAM Level 2.1)
- ☐ High- Intensity Outpatient Treatment (ASAM Level 2.5)
- ☐ Medically Managed Intensive Outpatient Treatment (ASAM Level 2.7)
- ☐ Opioid Treatment Program (if approved by SOTA)
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☐ **C) HOME and/or COMMUNITY SERVICES PROGRAM** ***(seen in the home and/or community only; never in the office)***

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*****This Addendum shall be submitted for <u>each</u> offsite; Make copies as needed*****