

Check one:  FNR Initial Application Or  Change of Ownership

Check all services for which you are applying:  Community Psychiatric Support and Treatment  Psycho-Social Rehabilitation

Mailed \$200 FNR Fee to DHH Licensing Payment, PO Box 734350, Dallas, TX 75373-4350

CHECK / MONEY ORDER # \_\_\_\_\_

FNR Supporting Documentation is attached to this FNR application

**I. FACILITY (DBA) NAME** \_\_\_\_\_

**GEOGRAPHIC ADDRESS (if applicable)** \_\_\_\_\_

**CITY / STATE / ZIP** \_\_\_\_\_

**ENTITY/CORPORATE NAME** \_\_\_\_\_

**CURRENT MAILING ADDRESS** \_\_\_\_\_ **City/State/Zip Code:** \_\_\_\_\_

**ENTITY PHONE NUMBER** \_\_\_\_\_

**II. APPLICANT'S DESIGNATED REPRESENTATIVE** \_\_\_\_\_

**DESIGNATED REPRESENTATIVE'S:** Telephone number (\_\_\_\_) \_\_\_\_\_ Fax Number(\_\_\_\_) \_\_\_\_\_  
Email address \_\_\_\_\_

**III. SERVICE AREA (Refer to FNR Rule/Regulation):** \_\_\_\_\_

**IV. ATTESTATION:**

*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. I acknowledge that Facility Need Review approval and licensure does not guarantee any form of reimbursement, including Medicaid.*

*Documentation of the information above is available upon request by the Louisiana Department of Health. I acknowledge that I have read the facility need review rule and will comply with the provisions therein.*

\_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)**

\_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE SIGNATURE**

\_\_\_\_\_  
**DATE**

*This Section to be completed by Health Standards Section Program Manager*

**APPLICATION #** \_\_\_\_\_

**DATE APPLICATION, DOCUMENTATION, AND FEE RECEIVED:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**FNR RECEIVED by (initials):** \_\_\_\_\_