Washington State Department of Health
Behavioral Health Agencies
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Revenue: 0597649550

Initial Licensure Application

Behavioral Health Agency and Certification for Mental Health, Substance Use Disorder, and/or Problem and Pathological Gambling Services

Section I: Demographic Information

☐ Association	☐ Limited Partnership	☐ Public Hospital District
☐ Corporation	☐ Municipality (City)	☐ Sole Proprietor
☐ Federal Government Agency	☐ Municipality (County)	☐ State Government Agency
☐ Limited Liability Company	☐ Non-Profit Corporation	☐ Tribal Government Agency
☐ Limited Liability Partnership	☐ Partnership	☐ Trust

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City		State	Zip code
Name of Agency as advertised on signs or website			
Physical Address			
City		State	Zip code
Phone (enter 10 digit #)		Fax number	
Mailing Address:			
City:	State:	Zip Code:	

All applicants must submit the following with this application:

- A copy of the report of findings from a criminal background check of any owner of 5 percent or more of the organizational assets.
- A copy of the agency's business license from the Department of Revenue that authorizes the organization to do business in the state of Washington.
- An application fee, in the form of a check or money order submitted to the address at the top of this page.

Section II: Agency Information

Funding Source Information

Is your agency BHO affiliated? ☐ Yes ☐ No

Please indicate the specific program service(s) for which your agency is seeking certification. For each service selected below, indicate if the service will receive public or private funding.

Outpatient Services		
(Check the box beside each specific program service for which your agency is seeking certification)	**Funding Source**	**Estimated # of Service Hours First 12 Months (each service)**
☐ Individual mental health treatment services		
☐ Brief intervention mental health treatment services		
☐ Group therapy mental health services		
☐ Family therapy mental health services		
☐ Rehabilitative case management mental health services		
☐ Psychiatric medication and medication support mental health services		
☐ Day support mental health services		
☐ Mental health services provided in a residential treatment facility **Required to have case management, LRA or conditional release support, and Psychiatric Medication and Medication Support services with this service.**		
☐ Supported employment mental health services		
☐ Supported employment SUD services		
☐ Supportive housing mental health services		
☐ Supportive housing SUD services		
☐ Peer support mental health services		
☐ Wraparound facilitation mental health services **Do you currently provide WISE services or plan on providing these services?** ☐ **Yes** ☐ **No**		
☐ Applied behavior analysis (ABA) mental health services		
☐ Clubhouse mental health services		
☐ SUD Level one outpatient services		
☐ SUD Level two intensive outpatient services		
☐ SUD Assessment only services		
☐ SUD Alcohol and drug information school services		
☐ SUD Information and crisis services		
☐ SUD Emergency service patrol services		
☐ SUD Screening and brief intervention services		
☐ Problem and Pathological gambling treatment services		
Involuntary and Court Ordered Outpatient Services		
(Check the box beside each specific program service for which your agency is seeking certification)	**Funding Source**	**Estimated Number of Service Hours First 12 Months (each service)**
☐ Less restrictive alternative (LRA) or conditional release support mental health services **Required to have Psychiatric Medication and Medication Support services with this service.**		
☐ Emergency involuntary detention designated crisis responder (DCR) mental health services		
☐ Emergency involuntary detention designated crisis responder (DCR) SUD services		
☐ Driving under the influence (DUI) SUD assessment services		

Crisis Mental Health Services		
(Check the box beside each specific program service for which your agency is seeking certification)	**Funding Source**	**Estimated Number of Service Hours First 12 Months (each service)**
☐ Crisis mental health telephone support services		
☐ Crisis mental health outreach services		
☐ Crisis mental health stabilization services		
☐ Crisis mental health peer support services		

Opioid Treatment Program (OTP) Services		
(Check the box for the specific program service for which your agency is seeking certification)	**Funding Source**	
☐ Opioid treatment programs (OTP)		

Withdrawal management, residential substance use disorder treatment, and mental health inpatient services		
(Check the box beside each specific program service for which your agency is seeking certification)	**Funding Source**	**Total Number of Beds (For Each Service)**
☐ Adult withdrawal management SUD services		
☐ Youth withdrawal management SUD services		
☐ Adult secure withdrawal management and stabilization SUD services		
☐ Youth secure withdrawal management and stabilization SUD services		
☐ Intensive inpatient SUD services		
☐ Recovery house SUD services		
☐ Long-term treatment SUD services		
☐ Youth residential SUD services		
☐ Adult evaluation and treatment mental health services		
☐ Youth evaluation and treatment mental health services		
☐ Child long-term inpatient program (CLIP) mental health services		
☐ Crisis stabilization unit mental health services		
☐ Voluntary triage mental health services		
☐ Involuntary triage mental health services		
☐ Competency evaluation and restoration treatment mental health services		

Additional Information to Submit

All applicants must submit:

☐ An electronic and/or hard copy of Administrative Policies and Procedures, and Clinical Policies and Procedures for each service for which you are applying for.

If you are applying for Opiate Treatment Program (OTP) certification, you must submit:

☐ An OTP Addendum form

☐ An OTP Community Relations Plan

Applicant Declarations

I declare the following:

- That I will notify the department if changes occur in any of the information provided in sections I and/or II of this application before licensure and certification is granted.
- That no person named in this application has had a license or certification for a treatment service or health care agency denied, revoked, or suspended.
- That no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse.
- That no person or business entity named in this application is currently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in transactions involving certain federal funds.
- That no person or business entity named in this application is currently under investigation for or has committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.
- That the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.

Signature of Administrator or Legal Representative	Date signed
Printed name of person signing form	Title

Phone number	Email

Contact Information

☐ Check here if same as above; if different, complete the information below

Applicant's contact name	Title
Phone number	Email

Privacy Notice

This notice is provided in compliance with Governor's Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this information.

Department of Health requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.

All information collected as a part of the certification process for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington RCW 42.56.230 through 290.

Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for as long as required by applicable law following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification.

Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.

For more information:
DSHS public disclosure law: RCW 42.56

Section III: Agency Facility and Personnel Information

☐ Check if you are including facility and personnel information section III, with this application.

☐ Check if you plan to send facility and personnel information section III, at a later date.
Note: Section III of this application must be submitted, reviewed, and approved before licensing and certification can be granted.

If checked, indicate the county in which you intend to provide the services: _____

☐ Check if you are sending section III of this application separately at a later date than sections I and II.

Date Sections I and II were sent: _____

Facility Information and Materials

Agency Email Addresses

Administrator:

Clinical Supervisor:

Agency Website Address

Agency:

Facility Application Materials

All Applicants must submit the following with section III:

☐ A floor plan of the facility that shows the location where all behavioral health services are to be provided and the dimensions of each room. See the sample floor plan provided with this application. The floor plan may be hand drawn. The reception area must be separate from all counseling and living areas.

☐ A statement assuring the agency meets American Disability Act (ADA) standards and that the facility is appropriate for providing the proposed services. Please complete the Accessibility Barrier Checklist found on our website.

Agency Personnel Information and Materials

Administrator providing management or supervision of services

Name	Title

Include with this application the following materials regarding the person named as administrator:

☐ Evidence that the administrator is appointed by the governing body, (a copy of a letter of appointment signed by a member of the governing body or a governing body signature on the administrator's job description).

☐ A copy of the job description signed and dated by the appointed administrator that includes the new administrator's commitment to performing the key responsibilities listed in WAC.

☐ A copy of the report of findings from a Washington State Patrol criminal background check conducted within the last year, and a copy of the report of findings of a criminal background check from the last state of residence if the person has lived out-of-state within the past three years.

Mental Health Clinical Supervisor

Name (as listed on the current credential)	Title

Substance Use Disorder Clinical Supervisor

Name (as listed on the current credential)	Title

Problem and Pathological Gambling Clinical Supervisor

Name (as listed on the current credential)	Title

Include the following materials regarding the person named as clinical supervisor:

☐ A copy of the job description signed and dated by the clinical supervisor and his or her supervisor.

☐ A copy of the report of findings from a Washington State Patrol criminal background check conducted within the last year, and a copy of the report of findings of a criminal background check from the last state of residence if the person has lived out-of-state within the past three years.

In addition for the Mental Health Clinical Supervisor:

☐ Documentation of 15 hours of training in clinical supervision approved by the Department of Health.

☐ For Agency Affiliated Registrations, please also include a copy of MHP recognition and/or a copy of Master's Degree and resume.

In addition for the Substance Use Disorder Clinical Supervisor:

☐ Documentation of 28 hours of training in clinical supervision approved by the Department of Health.

In addition for the Problem and Pathological Gambling Clinical Supervisor:

☐ Documentation of a valid international gambling counselor certification board-approved clinical consultant credential, a valid

Washington state certified gambling counselor II certification credential, or a valid national certified gambling counselor II

certification credential; and

☐ Documentation of training on gambling-specific clinical supervision approved by a state, national, or international organization.

Additional Personnel Requirements for Substance Use Disorder Agencies

Alcohol/Drug Information School (ADIS) Instructor (if applying for ADIS certification)

Name	Title

Submit the following materials regarding the person named as ADIS Instructor with this form:

☐ A copy of the job description signed and dated by the person named and the person's supervisor.

☐ If the ADIS Instructor is not a CDP, a copy of an Alcohol/Drug Information School Instructor Certificate issued by a community college approved by the Washington State Division of Behavioral Health and Recovery.

Agency Accreditation Information

Is your agency accredited? ☐ Yes ☐ No

If yes, check the organization that accredits your agency:

- ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ☐ Council on Accreditation (COA)
- ☐ The Joint Commission

Do you want to be contacted about becoming a "deemed agency"? ☐ Yes ☐ No

RCW/WAC and Online Website Links

WAC Link

Behavioral Health Agency, Chapter 246-341 WAC

Online

Behavioral Health Agencies Web Page