

## **Behavioral Health Agency (BHA) License Application Packet**

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### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Behavioral Health Agency Licensing  
P.O. Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

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## Application Instructions

All information should be printed clearly in blue or black ink.

When your application for a Behavioral Health Agency (BHA) license is received by the Department of Health, you will be notified of any outstanding documentation or licensing fees needed to complete the application process.

**Introduction:** Indicate the reason(s) why you are submitting this application by checking the box(s) that best describes why the application is being submitted.

**Tip:** You can use a single application to request multiple types of changes to a BHA license; however, if you are applying for or making changes to separate BHAs you will need to submit a separate application for each location.

**New Agency** - First time requesting a behavioral health agency license. Please complete the entire application. See checklist on page 4 for additional requirements.

**New Branch Site** - First time requesting a branch site license. Branch sites are physically separate licensed sites, governed by the same parent organization as the main site. Please complete the entire application. See checklist on page 4 for additional requirements.

**Tip:** If the branch site will be providing additional services that are not certified at the main site location, policies and procedures must be submitted for the additional services.

**Change of Location** - Request to change location of a currently licensed behavioral health agency. This will result in a new license. Please complete the entire application. See checklist on page 4 for additional requirements.

**Tip:** A licensed behavioral health agency must receive a new license under the new location's address before providing any behavioral health service at that agency.

**Change of Ownership** - Request by new prospective owner to change ownership of a currently licensed behavioral health agency. This will result in a new license. Please complete the entire application. See checklist on page 4 for additional requirements.

**Tip:** A change of ownership includes any transaction that results in a change of the Uniform Business Identification (UBI#) or federal tax identification #. The new agency must receive a new license under the new ownership before providing any behavioral health service.

**Renewal Applications** are required as of August 1, 2023 to renew a behavioral health agency license. Please complete the entire application. See checklist on page 4 for additional requirements.

**Tip:** Please see the [certification crosswalk](#) for help determining the revised certification and service titles. If you need assistance determining which certifications and services to include on your renewal application, please contact 360-236-2971.

**Tip:** If adding any new certifications or services at the time of renewal, policies and procedures will need to be submitted.

**Amend** - Request to update license information. Please complete sections I, V, and any other sections that relate to your amendment. See checklist on page 5 for additional requirements.

**Tip:** If adding any new certifications or services at the time of renewal, policies and procedures will need to be submitted.

**Section I: Business Information** – All applicants must complete this section.

**Section II: Agency Accreditation and Deemed Status** - Complete if you hold current accreditation status with a national accreditation organization that is recognized by and has a current agreement with the department.

**Tip:** This section will not apply to new agencies applying for an initial license.

**Tip:** Agencies that are accredited by a national accrediting organization may request deemed status by submitting a deeming application. Agencies that are deemed for the services they provide have lower licensing fees and do not receive routine surveys/inspections. Instead, they must submit the results of their accreditation surveys to the department.

**Section III: Key Individuals and Supervision** - Provide name, contact information, and other information that is requested for: Administrator, Contact Person, Clinical Supervisor(s), Opioid Treatment Program Sponsor (if applicable), and Opioid Treatment Program Medical Director (if applicable).

**Administrator:** When applying for a new license or when changing the administrator, include a copy of the disclosure statement and report of findings from a background check of the new administrator completed within the previous three months of the application date in accordance with [WAC 246-341-0300](#). Notification to the department of the change in administrator must be done within thirty days of the change in accordance with [WAC 246-341-0400](#).

**Clinical supervision** is required for mental health, substance use disorder/ withdrawal management, and problem and pathological gambling. Only opioid treatment programs are required to list the OTP sponsor and medical director.

**Tip:** For each clinical supervisor indicate the type of clinical service they are supervising. An appropriately credentialed professional may supervise more than one type of service.

**Section IV: Certification and Services Information** - Indicate whether you are requesting to “Add”, “Remove”, or “Continue” a certification and/or service in the left column and provide the requested information, where applicable, in the right column.

**Certifications:** Certification categories of services are bolded and shaded.

**Services:** Services are types of supports, interventions, or treatments provided under a certification.

**Mental health service hours:** Outpatient BHAs providing mental health services are required to report their total number of service hours which determines the licensing fee.

**Bed Counts:** Inpatient and residential BHAs are required to report the number of licensed beds which determines the licensing fee.

**Tip:** List the number of beds used to provide only mental health services, the number of beds used to provide only SUD or withdrawal management services, and the number of beds that will be used for dual purpose of providing mental health and SUD/withdrawal management services. Beds that are used for both mental health and SUD/withdrawal management services will be charged the SUD/withdrawal management fee rather than the mental health fee.

**Tip:** To indicate the total # of beds in your agency add up the number of mental health only, SUD/withdrawal management only, and dual service beds. The total number of beds must match the total number of beds you listed on your residential treatment facility license (if applicable).

**Section V: Applicant Declarations-** All applications must complete this section.

**Tip:** The application must be signed by the BHA administrator or legal representative who is designated by the administrator.

# Application Checklist

An application must be filled out in full and include additional information as follows:

## **New Behavioral Health Agency, submit:**

- Application (complete all sections)
- Policies and procedures
- Application fee - Check the [fee page](#) for current fees
- Administrator background check and disclosure statement
- Copy of Master Business License

## **Renew a BHA license, submit:**

- Application (complete all sections)
- Renewal fee - Check the [fee page](#) for current fees

## **Change of Ownership, submit:**

- Application (complete all sections)
- Policies and procedures
- Application fee - Check the [fee page](#) for current fees
- Administrator background check and disclosure statement
- Copy of Master Business License

## **Change of Location, submit:**

- Application (complete all sections)
- Policies and procedures (for any new services being provided)
- Application fee - Check the [fee page](#) for current fees
- Administrator background check and disclosure statement (if changing administrator, completed within the last three months of application date)

## **Open a New Branch Site, submit:**

- Application (complete all sections)
- Policies and procedures for any services that are not already certified at the main site location
- Application fee - Check the [fee page](#) for current fees
- Administrator background check and disclosure statement
- Copy of Master Business License

**Amend a BHA license, submit:**

- Application (complete all sections)
- Policies and procedures for added behavioral health services/certification
- Applicable fee for added services/beds- Check the [fee page](#) for current fees

**Change of Administrator only, submit:**

- Application sections I, III, & V
- Administrator background check and disclosure statement (completed within the last three months of application date)

**New Opioid Treatment Program, submit:**

- Application (complete all sections) [include Behavioral Health Outpatient Intervention, Assessment, and Treatment in Section IV]
- Policies and procedures
- Application fee - Check the [fee page](#) for current fees
- Administrator background check and disclosure statement completed within the last three months of application date
- Part 1 of the [Community Relations Plan](#)

Date  
Stamp  
Here

Revenue 0597649550

## Behavioral Health Agency (BHA) License Application Packet

This is for:

- |  |   |
|--|---|
| <input type="checkbox"/> <b>New Agency</b><br><br><input type="checkbox"/> <b>New Branch Site:</b><br>Main Agency License Number: _____<br><br><input type="checkbox"/> <b>Change of Location (New License):</b><br>Current Location License Number: _____<br>Effective Date of Location Change: _____<br><br>Will you be providing the same services at new location?<br><input type="checkbox"/> Yes <input type="checkbox"/> No (If no, submit policies and procedures) | <input type="checkbox"/> <b>Change of Ownership (New License)</b><br>Current Owner License Number: _____<br>Effective Date of Ownership Change: _____<br><br><input type="checkbox"/> <b>Renew an Existing BHA or Branch Site License</b><br>Current License Number: _____<br><br><input type="checkbox"/> <b>Amend an Existing BHA or Branch Site License</b><br>Current License Number: _____ |
|--|---|

### Section I. Business Information

Uniform Business Identification (UBI) #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Entity Name (as it appears on the Washington State Master Business License)			
Owner's 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 #)		Email Address	
Mailing Address			
City	State	Zip Code	
Agency Website Address (if applicable)			



## Section II. Agency Accreditation and Deemed Status

(This section will not apply to new agencies applying for an initial license)

Agencies that are accredited by a national accrediting organization may request deemed status by submitting a [deeming application](#). Agencies that are deemed for the services they provide, have lower licensing fees and do not receive routine surveys/inspections. Instead, they must submit the results of their accreditation surveys to the department.

- Accredited and deemed for mental health services  
 Accredited and deemed for substance use disorder services  
 Not accredited

## Section III. Key Individuals and Supervision

<b>Agency Administrator Name:</b>	<b>Date Appointed:</b>
Email:	Phone:
<b>Agency Contact Person Name:</b>	
Email:	Phone:
<b>Clinical Supervisor Name (as appears on credential):</b>	<b>Clinical Supervisor for:</b> <input type="checkbox"/> MH <input type="checkbox"/> SUD <input type="checkbox"/> PPG Credential #: _____
Email:	Phone:
<b>Clinical Supervisor Name (as appears on credential):</b>	<b>Clinical Supervisor for:</b> <input type="checkbox"/> MH <input type="checkbox"/> SUD <input type="checkbox"/> PPG Credential #: _____
Email:	Phone:
<b>Clinical Supervisor Name (as appears on credential):</b>	<b>Clinical Supervisor for:</b> <input type="checkbox"/> MH <input type="checkbox"/> SUD <input type="checkbox"/> PPG Credential #: _____
Email:	Phone:

### Opioid Treatment Program (OTP) Only

<b>Opioid Treatment Program Sponsor Name:</b>	
Email:	Phone:
<b>Opioid Treatment Program Medical Director Name (as it appears on credential):</b>	<b>Credential #:</b> _____
Email:	Phone:

## Section IV. Certification and Services Information

<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Behavioral Health Information Assistance</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Crisis Telephone Support	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Emergency Services Patrol	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Behavioral Health Support</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Psychiatric Medication Monitoring	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Crisis Support	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Peer Support	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Rehabilitative Case Management	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Day Support	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Supportive Housing	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Supported Employment	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Mental Health Peer Respite</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<input type="checkbox"/> # of beds _____	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Clubhouse</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Behavioral Health Outpatient Intervention, Assessment, and Treatment</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Assessments	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Counseling and Therapy	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Psychiatric Medication Management	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Outpatient Involuntary Court-Ordered Services - LRA/Conditional Release	<input type="checkbox"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Outpatient Involuntary Court-Ordered Services - DUI Assessment	

<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Outpatient Involuntary Court-Ordered Services - Deferred Prosecution	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Outpatient Involuntary Court-Ordered Services - SUD Counseling under RCW 41.61.5056	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Outpatient Involuntary Court-Ordered Services - Alcohol and Drug Information School	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Behavioral Health Outpatient Crisis, Observation, and Intervention</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Designation Crisis Responder Services</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Opioid Treatment Program</b> When applying for OTP Certification, you must also select certification title "Behavioral Health Outpatient Intervention, Assessment, and Treatment".	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Withdrawal Management</b>	<input type="checkbox"/> Adult :# of beds _____ <input type="checkbox"/> Youth:# of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Behavioral Health Residential or Inpatient Intervention, Assessment, and Treatment</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Residential and Inpatient Substance Use Disorder Treatment	<input type="checkbox"/> Adult :# of beds _____ <input type="checkbox"/> Youth:# of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Residential and Inpatient Mental Health Treatment	<input type="checkbox"/> Adult <input type="checkbox"/> Youth
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Involuntary Behavioral Health Residential or Inpatient</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Evaluation and Treatment	<input type="checkbox"/> Adult :# of beds _____ <input type="checkbox"/> Youth:# of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Evaluation and Treatment - CLIP	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Secure Withdrawal Management	<input type="checkbox"/> Adult :# of beds _____ <input type="checkbox"/> Youth:# of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Intensive Behavioral Health Treatment</b>	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Crisis Stabilization Unit</b>	<input type="checkbox"/> Voluntary: # of beds _____ <input type="checkbox"/> Involuntary: # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Competency Restoration</b>	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Problem Gambling and Gambling Disorder</b>	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	<b>Certification: Applied Behavior Analysis</b>	

## Service Hours and Bed Counts:

### Mental Health Service Hours

If this is a new license, report anticipated number of MH service hours for the first year of operation.

If this is a renewal, report the total number of annual MH service hours provided.

MH Service Hours: \_\_\_\_\_

### Bed Counts

# of beds for MH only: \_\_\_\_\_

# of beds for SUD only: \_\_\_\_\_

# of beds that are used for both MH and SUD (“dually certified”): \_\_\_\_\_

The total # of beds in my agency is: \_\_\_\_\_

## Section V. Application Declarations

I declare the following:

- That I will notify the department if changes occur in any of the information provided on this application.
- 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.
- That this agency meets the Americans with Disabilities Act (ADA) standards and that the facility is: Suitable for the purposes intended; is not a personal residence; and approved as meeting all building and safety requirements.

Signature of administrator or designated official

Date signed

Printed name of person signing the form

Title

Phone #

Email

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## Disclosure Statement

I, \_\_\_\_\_ have never been:

**1. Convicted of a crime against children or other persons.**

Aggravated murder; first or second degree murder; first or second degree kidnapping; first, second, third degree assault; first, second, or third degree assault of a child; first, second, or third degree rape; first, second, or third degree rape of a child; first or second degree robbery; first degree arson; first degree burglary; first or second degree manslaughter; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; child abuse or neglect as defined in [RCW 26.44.020](#); first or second degree custodial interference; malicious harassment; first, second, or third degree child molestation; first or second degree sexual misconduct with a minor; patronizing a juvenile prostitute; child abandonment; promoting pornography; selling or distributing erotic material to a minor; custodial assault; violation of child abuse restraining order; child buying or selling; prostitution; felony indecent exposure; criminal abandonment; or any of these crimes as they be rename in the future.

**2. Convicted of crimes relating to financial exploitation if the victim was a vulnerable adult.**

A conviction for first, second, or third degree extortion; first, second, or third degree theft; first or second degree robbery; forgery; or any of these crimes that may be renamed in the future. A vulnerable adult is an adult who lacks the functional, mental, or physical ability to care for themselves

**3. Convicted of crimes related to drugs;**

A conviction of a crime to manufacture, deliver, or possession with intent to manufacture or deliver a controlled substance.

**4. Found in any dependency action under [RCW 13.34.040](#) to have sexually assaulted or exploited any minor or to have physically abused any minor;**

**5. Found by a court in a domestic relations proceeding under Title 26 RCW to have sexually abused or exploited any minor or to have physically abused any minor;**

**6. Found in any disciplinary board final decision to have sexually or physically abuse or exploited any minor or developmentally disabled person or to have abused or financially exploited any vulnerable adult;**

Any final decision issued by a disciplining authority under [RCW 18.130](#) or the secretary of the department of health for the following businesses or professions: chiropractic, dentistry, dental hygiene, massage, midwifery, naturopathy, osteopathic medicine and surgery, physical therapy, physicians, practical nursing, registered nursing, and psychology.

**7. Found by a court in a protection proceeding under [RCW. 74.34](#), to have abused or financially exploited a vulnerable adult.**

The illegal or improper use of a vulnerable adult or that adult's resources for another person's profit or advantage.

Employee Signature \_\_\_\_\_ Date: \_\_\_\_\_

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## **RCW/WAC and Online Website Links**

### **Revised Code of Washington (RCW)**

[Community Mental Health Services Act - Chapter 71.24 RCW](#)

[Mental Illness - Chapter 71.05 RCW](#)

[Mental Health Services for Minors - Chapter 71.34 RCW](#)

### **Washington Administrative Code (WAC)**

[Behavioral Health Agency Licensing and Certification Requirements - Chapter 246-341 WAC](#)

### **Online**

[Behavioral Health Agencies Webpage](#)