

Tribal Attestation License Application Packet

Contents:

1. 611-017 Contents List/Mailing Information..... 1 Page
2. 611-018 Application Instructions Checklist 2 Pages
3. 611-019 Tribal Attestation Facility Application..... 4 Pages

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:**

Department of Health
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 doh.information@doh.wa.gov.

(This page intentionally left blank.)

Application Instructions Checklist

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

When your application for a Tribal facility license is received by the Department of Health (DOH), it will be reviewed, and you will be notified in writing of any outstanding documentation or attestation fees needed to complete the process.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

- ☐ **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. Include the existing attestation license number if renewing or amending a license. If switching a non-attested license to a tribal attestation, include the current license number.

Tip: If renewing an existing attestation or switching from a non-attested license to a tribal attestation, submit an attestation agreement form, license application, and fee.

- ☐ **Section I - Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #.

Federal ID Number (FEIN #): Enter your Federal ID Number, if the business has been issued one.

Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/Master Business License.

Mailing Address: Enter the owner's complete mailing address.

Facility/Agency Name: Enter the doing business as name. Name used on advertising, signs, and web sites.

Physical Address: Enter the facility's physical street location including city, state, zip code, and county.

Phone and Fax Numbers: Enter the agency's phone and fax number.

Mailing Address: Enter the agency's mailing address, if different than physical address.

Agency email and web address: Enter the agency's email and web address, if applicable.

☐ **Section II - Key Individuals:**

Administrator: Enter the administrator's name, email address, and phone number.

Contact Person: Enter the contact person's name, email address, and phone number.

For Opioid Treatment Programs only:

Program Sponsor: Enter the Program Sponsor's name, email address, and phone number.

Medical Director: Enter the Medical Director's name, email address, and phone number.

Tip: OTP certification is required if providing methadone and is subject to additional state and federal requirements including obtaining a drug other controlled substance registration from the Pharmacy Quality Assurance Commission, accreditation from a federally recognized accreditation body, and approval from the Substance Abuse and Mental Health Administration (SAMHSA), and the Drug Enforcement Administration (DEA).

- ☐ **Section III - Behavioral Health 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.

- ☐ **Include Attestation Form, if applicable, with completed application and appropriate [fee\(s\)](#).**

Tip: Only include an attestation agreement form if one does not already exist or if the existing attestation agreement is being amended to add a new facility type.

Date
Stamp
Here

Revenue 0597649550

Tribal Attestation License Application Packet

Check all that apply. This is for:

☐ Behavioral Health Agency ☐ Residential Treatment Facility ☐ Behavioral Health Hospital

I want to:

- ☐ License a new location
- ☐ Renew an existing license (Submit an attestation agreement form, license application, and fee)
Current License #: _____
- ☐ Amend a license (changing location or services) Current License #: _____
- ☐ Apply for a tribal attestation license and close current, non-attested license. (Submit an attestation agreement form, license application, and fee)
Current License #: _____

Section I. Demographic Information

Does your tribe have an existing attestation agreement: ☐ Yes ☐ No

UBI #

Federal Tax ID (FEIN) #

Legal Owner/Operator Name

Mailing Address

City

State

Zip Code

Name of Facility (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:

Section II: Key Individuals

Agency Administrator

Name:	Email:	Phone:
-------	--------	--------

Agency Contact Person

Name:	Email:	Phone:
-------	--------	--------

Opiod Treatment Program (OTP) Only

OTP Program Sponsor

Name:	Email:	Phone:
-------	--------	--------

OTP Medical Director

Name:	Email:	Phone:
-------	--------	--------

Section III. Behavioral Health Services Information

<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Behavioral Health Information Assistance	
<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	Certification: Behavioral Health Support	
<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"/> MH <input type="checkbox"/> SUD
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Supportive Housing	<input type="checkbox"/> MH <input type="checkbox"/> SUD

Section III. Behavioral Health Services Information Cont'd

<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	Certification: Mental Health Peer Respite	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Clubhouse	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Behavioral Health Outpatient Intervention, Assessment, and Treatment	
<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	Certification: Behavioral Health Outpatient Crisis Observation, and Intervention	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Designation Crisis Responder Services	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Crisis Relief Center	<input type="checkbox"/> # of recliners _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Opioid Treatment Program 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	Certification: 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	Certification: Behavioral Health Residential or Inpatient Intervention, Assessment, and Treatment	
<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	Certification: Involuntary Behavioral Health Residential or Inpatient	
<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	Certification: Intensive Behavioral Health Treatment	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Crisis Stabilization Unit	<input type="checkbox"/> Voluntary: # of beds _____ <input type="checkbox"/> Involuntary: # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Competency Restoration	<input type="checkbox"/> # of beds _____
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Problem Gambling and Gambling Disorder	
<input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Continue	Certification: Applied Behavior Analysis	
Bed/Recliner Counts:		
Total # of beds in my facility: _____		Total # of recliners in my facility: _____