Behavioral Health Agency (BHA) License Application Packet

Contents:

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 doh.information@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.

> **Outpatient service hours:** Outpatient BHAs providing mental health and/or substance use disorder services are required to report their total number of service hours which determines the licensing fee.

Bed/Recliner Counts: Twenty-three-hour crisis relief centers, inpatient, and residential BHAs are required to report the number of licensed beds and/or recliners 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 (completed within the last three months of application date)
- ☐ 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 (completed within the last three months of application date)
- ☐ 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 (completed within the last three months of application date)
- ☐ 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

Washington State Department of HEALTH

Date Stamp Here

Revenue 0597649550

Behavioral Health Agency (BHA) License Application Packet

This is for:

- ☐ **New Agency**
- ☐ **New Branch Site:**
  Main Agency License Number:_____
- ☐ **Change of Location (New License):**
  Current Location License Number:_____
  Effective Date of Location Change:_____
  Will you be providing the same services at new location?
  ☐ Yes ☐ No (If no, submit policies and procedures)
- ☐ **Change of Ownership (New License)**
  Current Owner License Number: _____
  Effective Date of Ownership Change: _____
- ☐ **Renew an Existing BHA or Branch Site License**
  Current License Number: _____
- ☐ **Amend an Existing BHA or Branch Site License**
  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

Agency Administrator Name:	**Date Appointed:**
Email:	Phone:
Agency Contact Person Name:	
Email:	Phone:
Clinical Supervisor Name (as appears on credential):	**Clinical Supervisor for:** ☐ **MH** ☐ **SUD** ☐ **PPG** Credential #:_____
Email:	Phone:
Clinical Supervisor Name (as appears on credential):	**Clinical Supervisor for:** ☐ **MH** ☐ **SUD** ☐ **PPG** Credential #:_____
Email:	Phone:
Clinical Supervisor Name (as appears on credential):	**Clinical Supervisor for:** ☐ **MH** ☐ **SUD** ☐ **PPG** Credential #:_____
Email:	Phone:

Opioid Treatment Program (OTP) Only

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

Section IV. Certification and Services Information

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

☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - SUD Counseling under RCW 41.61.5056	
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - Alcohol and Drug Information School	
☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Outpatient Crisis Outreach, Observation, and Intervention**	
☐ Add ☐ Remove ☐ Continue	23-Hour Crisis Relief Center Services	☐ # of recliners _____
☐ Add ☐ Remove ☐ Continue	**Certification: Designated Crisis Responder Services**	
☐ Add ☐ Remove ☐ Continue	**Certification: Opioid Treatment Program** When applying for OTP Certification, you must also select certification title “Behavioral Health Outpatient Intervention, Assessment, and Treatment”.	
☐ Add ☐ Remove ☐ Continue	**Certification: Withdrawal Management**	☐ Adult :# of beds _____ ☐ Youth:# of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Residential or Inpatient Intervention, Assessment, and Treatment**	
☐ Add ☐ Remove ☐ Continue	Residential and Inpatient Substance Use Disorder Treatment	☐ Adult :# of beds _____ ☐ Youth:# of beds _____
☐ Add ☐ Remove ☐ Continue	Residential and Inpatient Mental Health Treatment	☐ Adult ☐ Youth
☐ Add ☐ Remove ☐ Continue	**Certification: Involuntary Behavioral Health Residential or Inpatient**	
☐ Add ☐ Remove ☐ Continue	Evaluation and Treatment	☐ Adult :# of beds _____ ☐ Youth:# of beds _____
☐ Add ☐ Remove ☐ Continue	Evaluation and Treatment - CLIP	☐ # of beds _____
☐ Add ☐ Remove ☐ Continue	Secure Withdrawal Management	☐ Adult :# of beds _____ ☐ Youth:# of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Intensive Behavioral Health Treatment**	☐ # of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Crisis Stabilization Unit**	☐ Voluntary: # of beds _____ ☐ Involuntary: # of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Competency Restoration**	☐ # of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Problem Gambling and Gambling Disorder**	
☐ Add ☐ Remove ☐ Continue	**Certification: Applied Behavior Analysis**	

Service Hours and Bed Counts:

Outpatient Service Hours	Bed/Recliner Counts
If this is a **new license** (to include change of ownership or change of location), report anticipated number of Mental Health outpatient service hours. Please only include MH hours in this section. MH Service Hours: _____ If this is a **renewal**, report the total number of annual Mental Health and Substance Use Disorder outpatient service hours provided.	# 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: _____ The total # of recliners 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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Washington State Department of HEALTH

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 promotion 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