Behavioral Health Agency License Application Packet

Contents:

Important Information:

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 License
Credentialing
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.

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Application Checklist and Instructions

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

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

On page one of the application, indicate type of application—new, change of ownership, amended, change of location, branch site – new, or branch – amended.

- **New—**First time requesting a behavioral health agency license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of a licensed behavioral health agency. Any transaction that results in a change of the uniform business identification number or federal tax identification number. Include a statement from the current owner regarding the disposition and management of clinical records that meet applicable state and federal regulations.
- **Amended—**To modify your current behavioral health agency license.
- **Change of Location—**When a licensed behavioral health agency moves to a new location, resulting in a new physical address (to include a new suite number). Include license number of current location and a statement assuring the new location is suitable for the purposes intended, not a personal residence, and meets all applicable local and state building and safety requirements.
- **Branch Site – New** – When adding a new branch site location under a licensed behavioral health agency. Include license number and address of the main licensed behavioral health agency.
- **Branch Site – Amended** – To modify an existing branch location under a licensed behavioral health agency. Include license number and address of the main licensed behavioral health agency.

☐ **Application Fee:**

You can check the fee page for current fees.

☐ **Section I: Legal Entity InformationCheck One:**

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

☐ **Demographic Information:**

Uniform Business Identifier Number (UBI #): Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

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

Legal Owner/Operator Name: Enter the legal owner/operator entity name as it appears on the UBI/ Master Business License.

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

Agency Name: Enter the agency's name as advertised on signs, brochures, or Web site.

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

Phone and Fax Numbers: Enter the facility's phone and fax numbers.

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

Agency Web Address: Enter the agency web address, if applicable.

Section II: Agency Information

Agency Administrator and Contact Person: Enter name, email address, and phone number for the administrator and contact person that the department can contact about this application. The administrator listed must provide a copy of their most recent criminal history background check run directly through the Washington State Patrol.

Mental Health Non-Residential/Outpatient Level Services: Check the box beside each specific program service(s) for which your agency is seeking certification. Provide the estimated number of annual service hours beside each service that is selected.

Mental Health Residential/Inpatient Level Services: Check the box beside each specific program service(s) for which your agency is seeking certification. Provide the number of beds designated for each service that is selected.

Please note Applying for residential/inpatient services will require application of a residential treatment facility or hospital license. Updates made to an active behavioral health agency with residential/inpatient services could result in a required update to the residential treatment facility or hospital license.

Substance Use Disorder Non-Residential/Outpatient Services: Please check the box beside each specific program service(s) for which your agency is seeking certification.

Substance Use Disorder Residential/Inpatient Services: Please check the box beside each specific program service(s) for which your agency is seeking certification. Provide the number of beds designated for each service that is selected.

Please note Applying for residential/inpatient services will require application of a residential treatment facility or hospital license. Updates made to an active behavioral health agency with residential/inpatient services could result in a required update to the residential treatment facility or hospital license.

Problem and Pathological Gambling Services: Check the box if your agency is seeking certification.

Opioid Treatment Program Services: Check the box if your agency is seeking certification.

Please note This service requires the selection of SUD Level I outpatient and/or SUD Level II Intensive outpatient certification.

- Attach Section 1 of the Community Relations Plan for department review and approval.
- Enter OTP Sponsor name, title, phone and email address.
- Enter OTP Medical Director name, title, phone, email address and WA Medical License Number.

Agency Accreditation Information: Provide accreditation information, if applicable, to include the accreditation organization and the accreditation effective date and expiration date.
*****Please note* Your agency is eligible to apply to be deemed only if the agency is currently accredited by an approved accreditation organization. A separate deeming application is required.

Agency Clinical Supervisor Information: Enter the clinical supervisor name, title, and email address for each applicable service type your agency will provide. All clinical supervisors listed must provide a copy of their most recent criminal history background check run directly through the Washington State Patrol.

Applicant Declarations: Signed by the Administrator or Legal Representative. Must include the date signed, printed name of person signing the form, title, phone number, and email address.

Additional Information:

Return fully completed application and the following information:

- Applicable licensing and certification fees
- Copy of Master Business License
- Administrative and Clinical Policies and Procedures must be submitted prior to licensure.

  Note: If you are filing a change of location or amended application with no changes to the existing services your agency is providing, the policies and procedures are not required.
- Criminal History Background Check: Attach a copy of the current Washington State Patrol criminal history background check for the administrator, all clinical supervisors listed, and any owner of five percent or more of the organizational assets.

  Note: If you are filing an amended application with no changes to the current administrator, the criminal history background check is not required.
- Opioid Treatment Programs Only: Section 1 of the Community Relations Plan must be completed.

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Washington State Department of Health

Date Stamp Here

Revenue: 0597649550

Behavioral Health Agency License Application

☐ New ☐ Change of Ownership ☐ Amended ☐ Change of Location: Current license number _____

☐ Branch Site – New ☐ Branch Site – Amended

Branch Site Information

Main Site Address: _____

Main Site License Number: _____

Section I: Legal Entity Information

Check one:

☐ 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

Demographic Information

UBI #	Federal Tax ID (FEIN) #	
Legal Owner/Operator Entity 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
Agency Website Address		

Section II: Agency Information		
Agency Administrator		
Name:	Email:	Phone:
Agency Contact Person		
Name:	Email:	Phone:

Mental Health Non-Residential/Outpatient Level Services	**Estimated Number of Annual Service Hours**
Please check the box beside each specific program service(s) for which your agency is seeking certification.	
☐ Individual treatment	
☐ Brief intervention treatment	
☐ Less Restrictive Alternative (LRA)	
☐ Group therapy	
☐ Family therapy	
☐ Rehabilitative case management	
☐ Psychiatric medication management	
☐ Medication monitoring	
☐ Day support mental	
☐ Clubhouse	
☐ Designated crisis responder (DCR)	
☐ Crisis outreach	
☐ Crisis stabilization	
☐ Crisis telephone support	
☐ Mental Health Peer Respite Center	
☐ Applied behavior analysis (ABA)	
☐ Supported employment	
☐ Supportive housing	
☐ Peer support	
Mental Health Residential/Inpatient Level Services	**Number of beds**
Please check the box beside each specific program service(s) for which your agency is seeking certification.	
☐ Child Long-Term Inpatient (CLIP)	
☐ Crisis stabilization unit	
☐ Competency evaluation and restoration	
☐ Adult evaluation and treatment	
☐ Youth evaluation and treatment	
☐ Intensive Behavioral Health Treatment	
☐ Involuntary triage	
☐ Voluntary triage	

Substance Use Disorder Non-Residential/Outpatient Services
Please check the box beside each specific program service(s) for which your agency is seeking certification.
☐ Alcohol and drug information school
☐ Assessment only
☐ Emergency service patrol
☐ Information and crisis
☐ Level I outpatient
☐ Level II intensive outpatient
☐ DUI assessment

☐ Designated crisis responder (DCR)	
☐ Supported employment	
☐ Supportive housing	
☐ Peer support	
☐ Counseling services subject to RCW 46.61.5056	
Substance Use Disorder Residential/Inpatient Services	**Number of beds**
Please check the box beside each specific program service(s) for which your agency is seeking certification.	
☐ Adult withdrawal management	
☐ Youth withdrawal management	
☐ Adult secure withdrawal management and stabilization	
☐ Youth secure withdrawal management and stabilization	
☐ Intensive inpatient	
☐ Low-intensity recovery house	
☐ Long-term treatment	
☐ Youth residential	

Problem and Pathological Gambling Services

☐ Problem and Pathological Gambling

Opioid Treatment Program Services

☐ Opioid Treatment Program (This service requires the selection of Level I outpatient and/or Level II Intensive outpatient certification.)

Section 1 of the Community Relations Plan has been completed and is attached to this application for review and approval.

OTP Sponsor Name:	Title:
Phone:	Email:
OTP Medical Director Name:	Title:
Phone:	Email:
WA Medical License Number:	

Agency Accreditation Information

Is your agency accredited? ☐ Yes ☐ No Accreditation Effective Date _____

Accreditation Expiration Date _____

If yes, check the organization that accredits your agency:

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

☐ Council on Accreditation (COA)

☐ The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

☐ Department of Health (available for Opioid Treatment Programs only)

Agency Clinical Supervisor Information	
Mental Health Clinical Supervisor	
Name (as listed on the current credential)	Title
Email Address	
Substance Use Disorder Clinical Supervisor	
Name (as listed on the current credential)	Title
Email Address	
Problem and Pathological Gambling Clinical Supervisor	
Name (as listed on the current credential)	Title
Email Address	

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.
- That this agency meets Americans with Disabilities Act (ADA) standards and that the facility is: Suitable for the purposes intended; Not a personal residence; and Approved as meeting all building and safety requirements.

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

RCW/WAC and Online Website Links

WAC Link

Behavioral Health Agency, Chapter 246-341 WAC

Online

Behavioral Health Agencies Web Page