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 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.

Tip: Renewal applications are required as of August 1, 2023. Renewal applications received between August 1, 2023 and July 31, 2024 must have section V completed so that the new certification and services information that went into effect on May 1, 2023 can be recorded. 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.

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.

Check the box next to the facility type that best describes your agency. If your agency is a residential treatment facility (RTF) or hospital, include the license number of the RTF or hospital. Complete the rest of the information in Section I.

> **Tip:** You may also need to submit or amend your RTF or hospital application.
>
> **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 II: Opening or adding a BHA location – Complete this section only if you are opening or adding a location by checking the box next to the option that best describes what your agency is opening or adding.

> **Opening a new BHA as a result of a change in ownership**
>
> **Tip:** A change of ownership includes any transaction that results in a change of the Uniform Business Identification (UBI) # or federal tax identification #. Change of ownership requires an initial application from the new owner. The new agency must receive a new license under the new ownership before providing any behavioral health service.

Adding a new branch site

Tip: A branch site is a physically separate licensed site governed by the same parent organization as the main site. 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.

Adding a new BHA location to an existing hospital BHA license

Tip: This option is only available to hospitals that have an existing licensed BHA and are adding a new location under their existing hospital and BHA license. The location must be listed under the hospital license. Construction review is needed when locations are added to a hospital license.

If the location will be providing additional services that are not certified under the hospital BHA license, policies and procedures must be submitted for the additional services.

Section III - Amend an Existing BHA License—Complete this section only if you are amending an existing BHA license by checking the box next to the option(s) that best describes the amendment(s) you are requesting and following the applicable instructions in the application.

Tip: When adding a certification, the amended application must be submitted before providing the behavioral health services listed under the certification.

Tip: When adding a service, the agency must be certified for the category of service in order to add the service. The amended application will serve as "notification" and must be submitted to the department within 30 calendar days of beginning the service.

Tip: When closing a location complete the additional information including listing the name, address, and contact information of the licensed agency or entity storing and managing clinical records.

Tip: When changing the administrator complete the additional information and 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.

Section IV - Change of Location—Complete this section only if the physical address or the suite # of the BHA is changing.

Tip: A change in location will result in a new credential # being issued.

Section V – Behavioral Health Services- Complete this section when opening a new BHA or branch site, renewing a BHA license, adding certifications or services to a BHA, or cancelling certifications or services. Complete the section by listing the clinical supervisor for the services your agency will provide, and checking “add” next to the certifications or services that will be new, checking “remove” next to certifications or services being discontinued, or “continue” next to the certifications or services your agency currently provides and will continue to provide. In the far-right column provide the information as applicable for outpatient mental health service hours or residential and inpatient bed counts.

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.

Certifications: Certifications group categories of services and are bolded and shaded. If opening a new BHA, or adding or canceling certifications, check the box next to the certification(s) and check the box(s) under the certification indicating they type of services you will provide or discontinue under that certification. Provide the requested information (as applicable) in the column on the right.

Services: Services are types of supports, interventions, or treatments provided under a certification. If opening a new BHA, adding a new certification, or adding or canceling a service under an existing certification check the box next to the service(s) under the certification and provide the requested information (as applicable) in the column on the right.

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.

Tip: Add up the total number of mental health services hours that were recorded in the chart above.

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.

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 listed on your residential treatment facility license (if applicable).

Section VI - 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 sections I, II, V, VI)
- ☐ 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 sections I, V, VI)
- ☐ Policies and procedures (for any new certifications or services being provided)
- ☐ Application fee - Check the fee page for current fees

Change of Ownership, submit:

- ☐ Application (complete sections I, II, V, VI)
- ☐ 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

Open a New Branch Site, submit:

- ☐ Application (complete sections I, II, V, VI)
- ☐ 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

New Hospital BHA Location, submit:

- ☐ Application (complete sections I, II, VI) Note: complete section V if providing services the hospital BHA is not already certified to provide)
- ☐ Policies and procedures (for any certifications or services the hospital BHA is not already approved to provide)
- ☐ Assure additional location is listed under the hospital facility license (if not, amend hospital license to include additional location which will require construction review approval)

Add a New Behavioral Health Service/Certification, submit:

- ☐ Application (complete sections I, III, V, VI)
- ☐ Policies and procedures for added behavioral health services/certification
- ☐ Application fee - Check the fee page for current fees

Remove/Cancel a Behavioral Health Service/Certification, submit:

- ☐ Application (complete sections I, III, V, VI)

Closing a Location, submit:

- ☐ Application (complete sections I, III, VI)

Change of Administrator, submit:

- ☐ Application (complete sections I, IV, VI) Note: complete section V if changing any services
- ☐ Policies and procedures (for any new services being provided)
- ☐ Application fee - Check the fee page for current fees
- ☐ Administrator background check and disclosure statement (completed within the last three months of application date)

New Opioid Treatment Program, submit:

- ☐ Application (complete sections I, II, V [include outpatient assessment, intervention, and treatment], and VI
- ☐ 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

I want to:

- ☐ Open a BHA or add a branch site
- ☐ Open a new BHA due to change of ownership
- ☐ Amend an existing BHA license
- ☐ Change the location of a BHA
- ☐ Renew a BHA license - BHA license # _____

Section I. Business Information

This application is for a BHA that is a(n): (check one)

- ☐ Outpatient agency
- ☐ Residential Treatment Facility (RTF): Associated RTF license # (if applicable): _____
- ☐ Psychiatric hospital: Associated hospital license # (if applicable): _____
- ☐ Acute care hospital: Associated hospital license # (if applicable): _____

WA UBI #	Federal Tax ID (FEIN) # (if issued)
Legal Owner/Operator Entity Name (as it appears on the UBI)	
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)		

Agency Accreditation and Deemed Status:

☐ Accredited and deemed for all services ☐ Accredited and deemed for some services ☐ Not Accredited

Agency Contact Person	
Email	Phone
Agency Administrator	
Email	Phone

Section II. Opening or Adding a Location

I am:

☐ Opening a new BHA

☐ Opening a new BHA due to a change in ownership

BHA license # of the agency that is changing ownership: _____

Date of proposed change of ownership: _____

☐ Opening a new branch site BHA:

Main site BHA license #: _____

Will this branch site be providing additional services that are not certified at the main site: ☐ Yes ☐ No

☐ Adding a new BHA location to an existing hospital BHA license:

Existing hospital BHA license #: _____

Is the physical location of this BHA listed under the hospital facility license? ☐ Yes ☐ No

(If no, submit a hospital application to add the location to the hospital license)

Will this location be providing additional services that are not certified under the existing hospital BHA license? ☐ Yes ☐ No

Section III. Amend a License

BHA license # that is being amended: _____

I am:

☐ Adding a certification

☐ Removing a certification

☐ Adding behavioral health service(s) under an existing certification

☐ Removing a behavioral health service(s) under an existing certification

☐ Closing a location:

Date of closure: _____

Custodian of records (name, address, phone): _____

☐ Changing the administrator:

New administrator name: _____

Date appointed: _____ Email: _____ Phone: _____

Section IV. Change of Location

New Address

City	State	Zip Code

Will you be providing the same services? ☐ Yes ☐ No

Will you have the same administrator? ☐ Yes ☐ No

BHA license # that is changing locations: _____

Section V. Supervision, Certification, and Services

Clinical Supervisor for: ☐ MH ☐ SUD ☐ PPG	**Clinical Supervisor for**: ☐ MH ☐ SUD ☐ PPG
Name (as it appears on the credential):	Name (as it appears on the credential):
_____	_____
Credential #: _____	Credential #: _____
Email: _____	Email: _____
Phone: _____	Phone: _____
Opioid Treatment Program Sponsor:	**Opioid Treatment Program Medical Director:**
Name: _____	Name (as it appears on the credential):
Email: _____	_____
Phone: _____	Credential #: _____
	Email: _____
	Phone: _____

☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Information and Assistance**	
☐ Add ☐ Remove ☐ Continue	Crisis Telephone Support	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Emergency Services Patrol	
☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Support**	
☐ Add ☐ Remove ☐ Continue	Psychiatric Medication Monitoring	☐ MH: # of service hours _____
☐ Add ☐ Remove ☐ Continue	Crisis Support	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Peer Support	☐ MH: # of service hours _____ ☐ SUD

☐ Add ☐ Remove ☐ Continue	Rehabilitation Case Management	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Day Support	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Supportive Housing	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Supported Employment	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	**Certification: Mental Health Peer Respite**	☐ # of beds _____
☐ Add ☐ Remove ☐ Continue	**Certification: Clubhouse**	☐ # of service hours _____
☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Outpatient Intervention, Assessment, and Treatment**	
☐ Add ☐ Remove ☐ Continue	Assessments	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Counseling and Therapy	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Psychiatric Medication Management	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - LRA/Conditional Release	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - DUI Assessment	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - Deferred Prosecution	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - SUD Counseling under RCW 41.61.5056	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	Outpatient Involuntary Court-Ordered Services - Alcohol and Drug Information School	☐ MH: # of service hours _____ ☐ SUD
☐ Add ☐ Remove ☐ Continue	**Certification: Behavioral Health Outpatient Crisis, Observation, and Intervention**	☐ # of service hours _____
☐ Add ☐ Remove ☐ Continue	**Certification: Designation Crisis Responder Services**	☐ # of service hours _____
☐ Add ☐ Remove ☐ Continue	**Certification: Opioid Treatment Program**	
☐ 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 # of service hours _____
☐ 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**	☐ Adult ☐ Youth # 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**	☐ # of service hours _____

Service Hours and Bed Counts:

Mental Health Service Hours:	Bed Counts:
Based on the information provided above, the total # of MH service hours my agency provides is: _____	# 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 VI. 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

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