

**ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES**

150 N. 18th Avenue Suite 410 •• Phoenix, Arizona 85007

INITIAL APPLICATION FOR A BEHAVIORAL HEALTH SERVICE AGENCY LICENSE

A.R.S. Title 36, Chapter 4 and A.A.C. Title 9, Chapter 20

I. BEHAVIORAL HEALTH SERVICE AGENCY INFORMATION

Name of behavioral health service agency			
Street address			
City			Zip code
Mailing address			
City		State	Zip code
Phone number	Fax number	E-Mail address	Tax I.D. Number
Requested behavioral health service agency subclasses: (listed in R9-20-102.A)			
The location of each subclass on the behavioral health service agency's premises:			
The behavioral health services for which the agency is requesting authorization: (listed in R9-20-102.B) Please list the services for each licensed sub-class required.			
The population for whom the applicant intends to provide behavioral health services:			
The requested licensed bed capacity for the behavioral health residential and/or inpatient service agency:			

For an agency that provides inpatient and/or residential behavioral health services:
 Number of beds requested for individuals younger than 18 years of age:
 Level 1 Inpatient: _____ Level 2 & 3 Residential: _____ Level 4 Transitional: _____

Number of beds requested for individuals 18 years of age or older:
 Level 1 Inpatient: _____ Level 2 & 3 Residential: _____ Level 4 Transitional: _____

Number of: Toilets _____ Sinks _____ Showers _____ Tubs _____

Is the behavioral health service agency a secure facility? Yes No
 If yes, the number of beds designated for individuals younger than 18 years of age _____ and the number of beds designated for individuals 18 years of age or older _____.

Is the applicant requesting certification under Title XIX of the Social Security Act for the behavioral health service agency?
 Yes No

Is the behavioral health service agency accredited by a nationally recognized accreditation organization?
 Yes No

If yes, please include the following information:
 Name of accreditation organization: _____.

Dates of the accreditation period MM/DD/YY _____ to MM/DD/YY _____.

If the behavioral health service agency is accredited by the Joint Commission on Accreditation of Health Care Organizations, is the behavioral health service agency accredited under the:
 Inpatient hospital standards? Yes No
 Community behavioral health standards? Yes No

Does the behavioral health service agency have a contract with a Government entity such as: (please check those that apply)
 The Administrative Office of the Courts Department of Juvenile Justice
 Department of Economic Security Tribal Government

Does the behavioral health service agency have a contract with a Regional Behavioral Health Authority? Yes No
 Please check the applicable boxes. (See attachment for geographical area designation on page 7)

- | | | |
|-------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> MAGELLAN | <input type="checkbox"/> CPSA3 | <input type="checkbox"/> CPSA5 |
| <input type="checkbox"/> CENPATICO2 | <input type="checkbox"/> CENPATICO4 | <input type="checkbox"/> NARBHA |

TRBHA:

<input type="checkbox"/> NAVAJO NATION	<input type="checkbox"/> COLORADO RIVER	<input type="checkbox"/> GILA RIVER
<input type="checkbox"/> PASCUA YAQUI	<input type="checkbox"/> WHITE MOUNTAIN APACHE	

For an applicant that is seeking initial licensing, please indicate if you are ready for an inspection by Department Representatives?
 Yes No If no, indicate the date the applicant will be ready: _____

II. OWNER INFORMATION

Owner' Name:		
Address:		City:
Zip code:	Phone Number	Fax Number
The owner is a: (check one)	<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Partnership
<input type="checkbox"/> Limited liability company	<input type="checkbox"/> Corporation	<input type="checkbox"/> Governmental Agency

Has the person applying for a license or a person with 10% or more business interest in the agency previously held a health care institution license in any state or jurisdiction?

Yes No If yes, include on a separate sheet of paper:

1. The health care institution's name,
2. The license number, and
3. The dates of licensure.

Has the person applying for a license or a person with 10% or more business interest in the agency had a license to operate a health care institution denied, revoked or suspended?

Yes No

Has the person applying for a license or a person with 10% or more business interest in the agency had a professional or occupational license, other than a driver's license, denied, revoked or suspended?

Yes No

Has the person applying for a license or a person with 10% or more business interest in the agency had civil penalties assessed against a health care institution operated in any state by the person applying for a license or the owner?

Yes No

Has the person applying for a license or a person with 10% or more business interest in the agency been convicted, in any state or jurisdiction, of any felony?

Yes No

Has the person applying for a license or a person with 10% or more business interest in the agency been convicted, in any state or jurisdiction, of any misdemeanor involving moral turpitude, including conviction for any crime involving abuse, neglect, or exploitation of another?

Yes No

If any of the above questions are answered yes, include on a separate sheet of paper for each yes answer:

1. The type of action;
2. The date of the action; and
3. The name and address of the court or entity having jurisdiction over the action.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the behavioral health service agency subclasses for which licensure is requested)	
Experience (list work experience related to the behavioral health service agency subclasses for which licensure is requested)	

Attach:

1. If applicable, a copy of the articles of incorporation, partnership or joint venture documents, or limited liability documents;
2. A program description required in A.A.C. R9-20-201(A)(2);
3. If applicable, a listing of the agency’s branch offices including each branch office’s address, hours of operation, and behavioral health services provided at the branch office;
4. A document issued by the local jurisdiction with authority certifying that the facility complies with all applicable local building codes;
5. A copy of a current fire inspection conducted by the local fire department or the Office of the State Fire Marshall and any plan of correction in effect;
6. If the agency is required to have a food establishment license pursuant to 9 A.A.C. 8, Article 1, a copy of the most recent food establishment inspection report for the agency;
7. If applicable, a copy of the behavioral health service agency’s accreditation report;
8. A list of each staff member, intern, or volunteer employed or under contract with the behavioral health service agency including:
 - a. Whether each staff member is a behavioral health professional, behavioral health technician, or behavioral health paraprofessional;
 - b. Each behavioral health professional’s occupation or professional license or certification number; and
 - c. If applicable, each staff member’s fingerprint clearance card number; and
9. An organizational chart showing all behavioral health service agency staff member positions and the lines of supervision, authority, and accountability.
10. Is the proposed health care institution located less than 400 feet of agricultural land?

Yes No

If yes:

 - a. Include on a separate sheet of paper the names and addresses of owners or lessees of any agricultural land less than 400 feet of the proposed health care institution, and
 - b. Attach a copy of the written agreement between the health care institution owner and the owner or lessee of agricultural land prescribed in A.R.S. § 36-421(D).
11. Notice of Readiness.

Geographical Service Area (GSA)	Name of Regional Behavioral Health Authority (RBHA)	County
GSA 1	NARBHA	Mohave, Coconino, Apache, Navajo, and Yavapai
GSA 2	Cenpatico 2	Yuma and La Paz
GSA 3	CPSA 3	Graham, Greenlee, Santa Cruz, and Cochise
GSA 4	Cenpatico 4	Pinal and Gila Counties
GSA 5	CPSA 5	Pima
GSA 6	Magellan	Maricopa