

# **INSTRUCTIONS FOR BEHAVIORAL HEALTH LICENSING APPLICATION**

## **I. AGENCY INFORMATION**

Self explanatory – Refer to Arizona Administrative Code, Title 9, Chapter 20, Behavioral Health Agency, as referenced in the application.

Entity Affiliation – If the agency contracts with or receives funding as a subcontractor of a Regional Behavioral Health Authority, indicate all affiliations that are applicable. If none, indicate N/A. If the agency has accreditation, indicate the accrediting organization, and month, day, and year of accreditation period.

## **II. OWNER INFORMATION**

If the behavioral health facility is to be operated as a non-profit organization or a government agency, the name, title, address, and phone number of the Chief Executive Officer must be shown in this block. If additional space is required, a separate sheet may be used to provide additional information.

If ownership is by an individual, the individual's name must be shown in this block. If ownership is by a partnership, at least two general partners' names and addresses, other than the facility, must be shown.

Licensure/Applicant History – Any "YES" response requires a separate attachment, which provides applicable detailed information.

Statutory agent – Refer to A.R.S. Title 10 for laws on corporations and limited partnerships. Other types of businesses must name an individual designated to accept service of process and subpoenas.

## **III. GOVERNING AUTHORITY**

Refer to Arizona Administrative Code Title 9, Chapter 20, Definitions.

## **IV. CHIEF ADMINISTRATIVE OFFICER**

Indicate the name of the chief administrative officer who is responsible for implementing the policies and ensuring that all Department rules are in compliance. The name of the alternative administrative officer, who is designated to assume the duties in the absence of the chief administrative officer, must also be indicated. **IF THERE IS A CHANGE OF THIS DESIGNEE DURING THE LICENSING PERIOD, THE OFFICE OF BEHAVIORAL HEALTH LICENSING MUST BE NOTIFIED IN WRITING WITHIN 30 DAYS AFTER THE CHANGE.**

Program Description – This description should be a stand-alone document that is detailed and specific as indicated in R9-20-201(A)(2). All information must be included and not referenced by policy or rule. If more than one license is being sought, or more than one type of service will be offered, a separate description must be attached for each.

"Branch Office" Information – As per R9-20-101.19 A "Branch Office" is an off-site office used periodically but less than 20 hours per week by an outpatient clinic or an outpatient program offered by a hospital licensed pursuant to A.A.C. Title 9, Chapter 10, Articles 2,3, or 4.

Organization Chart – Must indicate all staff who provide behavioral health services, as well as administrative and supervisory line of authority within the program or agency.

## **V. APPROVAL OF DUI FACILITIES**

These requirements are to be completed only if the applicant is applying for approval as a DUI Service Agency.

## **VI. SIGNATURES**

A.R.S. § 36-422.b STATES, "The application shall be signed, in the case of an individual, by the owner of the health care institution, or in the case of a partnership or a corporation, by two of the officers hereof, or by principle board member if a single person corporation, or in the case of a governmental unit, by the head of the governmental department having jurisdiction thereof."

Dear Provider:

The following check list is provided to assist you in determining the completeness of your agency's licensure application prior to submittal to the Office of Behavioral Health Licensure. It is hoped that the use of this tool will expedite the application review process and, decrease the on-site survey time spent clarifying required information.

- Mailing address if different from facility address
- A copy of the articles of incorporation, bylaws, partnership or joint venture documentation (Initials)
- Documentation of facility complying with the local building codes, A.A.C. R9-20-103.A.1.1.  
(e.g., Certificate of Occupancy) (Initials)
- Attestation Letter (Level I & RTC Facilities Only)
- Qualifications of administrator per Section IV of application
- If deemed status is requested, please list accreditation organization and ensure the accreditation period dates are entered per Section I.
- Accreditation Report (for this specific address)
- Organizational Chart
- Current Fire Inspection
- Current Sanitation Inspection (if applicable)
- Copy of previous license (if applicable)
- Program Description required in A.A.C. R9-20-201(A) (2)
- List of staff member, behavioral health professional, BH technician or BH paraprofessional
- List of staff member, behavioral health professional, BH technician or BH paraprofessional working with children
- Copy of fingerprint certification cards, if applicable
- DUI Formal Referral Procedures With One Or More Courts (if applicable)
- DUI Screening Instrument (if applicable)
- DUI Educational Curriculum Used In Program (if applicable)
- DUI Fees For Services (should be in program description)
- DVTX Fees For Services (should be in program description)
- Signature(s) Are Present
- Notice of Readiness (initial applications only)
- Other:

We hope this checklist will be of assistance to you. As always, should you have any questions or require additional information, please contact the Office of Behavioral Licensure at (602) 364-2595.

**OFFICE OF BEHAVIORAL HEALTH LICENSURE**

150 N. 18<sup>th</sup> Avenue., Suite. 410

Phoenix, AZ 85007

<b>HEALTH CARE INSTITUTION RENEWAL APPLICATION AND LICENSE FEE REMITTANCE FORM</b>				
<b>PLEASE RETURN THIS FORM WITH THE PAYMENT TO THE ADDRESS ABOVE</b>				
<b>LICENSE #:</b>				
<b>APPLICANT/ENTITY NAME:</b>				
<b>FACILITY NAME:</b>				
<b>STREET ADDRESS:</b>			<b>SUITE #:</b>	
<b>CITY:</b>		<b>STATE:</b>	<b>ZIP:</b>	
<b>FEES</b>			<b>AMOUNT DUE</b>	
Application Fee (Please do not submit the application fee if the fee has already been paid.)			\$ 50.00	
<b>LICENSED CAPACITY</b>				
<b>Check One:</b>	<b>Licensed Capacity:</b>	<b>Base Fee:</b>	<b>Number of Beds x \$25.00 each:</b>	<b>Total base fee plus number of beds fee:</b>
	None	\$ 100.00	0	\$100.00
	1 to 59 beds	100.00		
	60 to 99 beds	200.00		
	100 to 149 beds	300.00		
	150 or more beds	500.00		
<b>TOTAL AMOUNT DUE</b>				<b>\$</b>
<b>Payment should be by cashier=s check, money order or business check made payable to: ARIZONA DEPARTMENT OF HEALTH SERVICES</b>				
Write the Facility License # on the check. Cash and personal checks are not accepted.				
<b>AMOUNT ENCLOSED</b>				<b>\$</b>

**ALL FEES ARE NON-REFUNDABLE** pursuant to A.R.S. ' 36-405(c), 36-882(f) and 36-897.01(c), except as provided in A.R.S. ' 41-1077.

## Program Description

This check off sheet can help you set up your program description. **It is NOT a substitute for the rules.** Please refer to the rule number and read the rule thoroughly before developing your program description.

Double-check your written program against this list to assure that you have included everything that is required prior to submitting it with your application.

The program description is described in **R9-20-201 A.2.** , which states, “For each subclass for which the licensee is licensed, adopt, maintain, and have available at the agency for public review, a current written program description that includes:”

- Subclass
- Goals
- Description
- Counseling for individual, family, group, type, of issue, type and amount offered
- Population
- Hours and Days
- Location of services/and specify what services
- Criteria for admitting/re-adopting, waiting list, referral, discharge, transferring, declining services
- Staff’s minimum qualifications, experience, training, and skills necessary in relation to the behavioral health services provided and population served
- Fees and refunds
- Non-English speaking clients
- Accommodations for physical disabilities
- Partial care – days/times counseling/medication provided
- Inpatient – specify whether it is a secure facility, describe staff ratios for all shifts, and client personal funds account
- Emergency safety response

BH: \_\_\_\_\_

**NOTICE OF READINESS  
IMPORTANT NOTICE REQUIRING A REPLY!**

Please indicate that you have reviewed the requirements below and are ready for the licensing survey by signing and returning the completed form to the OBHL at:

**ADHS  
Office of Behavioral Health Licensing  
150 N. 18<sup>th</sup> Ave. Suite 410  
Phoenix, AZ 85007-3242**

- All policies and procedures required by Arizona Administrative Code Chapter 20 have been developed, approved, and implemented. Documentation of the policy approval has been completed and is ready for review.
- All personnel files are in compliance with R9-20-204, R9-20-205, R9-20-206, R9-20-207, and any other portion of the licensing rules as applicable depending upon agency subclass and service provision. The personnel files are ready for review.
- All environmental aspects identified in R9-20-214 and R9-20-405, if applicable, and any other portion of the licensing rules as applicable depending upon agency subclass and service provision are in compliance and are ready to be inspected.
- A mock client file has been developed according to R9-20-211 and any other portion of the licensing rules as applicable depending upon agency subclass and service provision and is ready to be reviewed.

Please provide a date range indicating the Month and the day dates when the agency will be ready for inspection according to the above content areas:

MONTH	MON	TUE	WED	THR	FRI	MON	TUE	WED	THR	FRI

Please provide the name of the person to be contacted to schedule the on-site survey:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date