



INITIAL PROVIDER APPLICATION FOR LICENSING
Code of Virginia §37.2-405 & §35-46

Please use a typewriter or print legibly using permanent, black ink. The chief executive officer, director, or other member of the governing body who has the authority and responsibility for maintaining standards, policies, and procedures for the service may complete this application.

1. APPLICANT INFORMATION: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ County \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone:( ) \_\_\_\_\_ Email: \_\_\_\_\_

Names of all Owners and the percentage (%) of the organization owned by each \_\_\_\_\_

Chief Executive Officer or Director. Identify the person responsible for the overall management and oversight of the service(s) to be operated by the applicant.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone:( ) \_\_\_\_\_ Fax Number:( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

All Residential Services: (The liaison is the staff that shall be responsible for facilitating cooperative relationship with neighbors, the school system, local law enforcement, local government officials and the community at large.)

Community Liaison Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ E-mail \_\_\_\_\_

2. ORGANIZATIONAL STRUCTURE: Identify the organizational structure of the applicant's governing body.

Check one(1) of the following:

[ ] Non-Profit [ ] For-Profit

Check one(1) of the following:

[ ] Individual (proprietorship) [ ] Partnership
[ ] Corporation [ ] Unincorporated Organization or Association

Public agency:

[ ] State [ ] Community Services Board [ ] Other \_\_\_\_\_

Identify accrediting or certifying organization from the following, if applicable:

[ ] Accreditation Council for Services for People with Developmental Disabilities [ ] Virginia Association of Special Education Facilities
[ ] Joint Commission on Accreditation of Health Care Organizations [ ] Other associations or organizations:
[ ] Commission on Accreditation of Rehabilitation Facilities \_\_\_\_\_

3. APPLICANT PARENT COMPANY INFORMATION: Identify the parent company of person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone:( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

**SERVICE TYPE:**

Place a check to identify the service type. If the service type is not listed, please note in the service information section. Please note new applicants (no independent service operation experience) are permitted to apply for **ONE** service on the initial application.

Check one	Service	Pgm	Description	Licensed As Statement
	14	001	Level C MH Children Residential Service	A Level C mental health children's residential service for children with serious emotional disturbance
	14	001	Level C MH Children Residential Service	A Level C mental health children's residential service for children with serious emotional disturbance
	14	004	MH Children Residential Service	A mental health children's residential service for children with serious emotional disturbance
	14	007	SA Children Residential Service	A substance abuse children's residential service for children
	14	008	MH Children Group Home Residential Service	A mental health group home residential service for children with serious emotional disturbance
	14	033	SA Children Group Home Residential Service	A substance abuse group home residential service for children
	14	035	DD Children Group Home Residential Service	A developmental disability group home residential service for children
	14	048	ICF-IDD Children Group Home Residential Service	An intermediate care facility for individuals with a developmental disability (ICF-IDD) group home residential service for children
	14	59	REACH Children's Residential Service	A residential group home with crisis stabilization REACH service for children and adolescents with a co-occurring diagnosis of developmental disability and behavioral health needs

**5. SERVICE INFORMATION:** Complete for the organization to be licensed by the Department of Behavioral Health and Developmental Services.

**Service Director:** \_\_\_\_\_

**Phone:** (    ) \_\_\_\_\_ **E-Mail** \_\_\_\_\_

Client Demographics (check all that apply):

Male    Female    Both                       Child                       Adolescent (Min. & Max. Age Range) \_\_\_\_\_  Adult

**LOCATION**

**6. Location Name** \_\_\_\_\_ **# of beds:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Location Manager:** \_\_\_\_\_ **Phone:**(    ) \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Directions:** \_\_\_\_\_

**7. NAME AND ADDRESS OF OWNER OF PHYSICAL PLANT**

Name	
Address	

**8. RECORDS: IDENTIFY THE LOCATION OF THE FOLLOWING RECORDS**

<b>Financial Records</b>	<b>Address:</b> _____ <b>City:</b> _____ <b>County</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>Personnel Records</b>	<b>Address:</b> _____ <b>City:</b> _____ <b>County</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>Residents' Records</b>	<b>Address:</b> _____ <b>City:</b> _____ <b>County</b> _____ <b>State:</b> _____ <b>Zip:</b> _____

<b><u>REQUIRED ATTACHMENTS</u></b>	<b><i>Children's Residential Service Regulations</i></b>	<b><i>All Other Services Regulations</i></b>
1. <input type="checkbox"/> <b>The Completed Application form</b>	§12 VAC 35-46-20 (D)(1)	§35-105-40(A)
2. <input type="checkbox"/> <b>A Working Budget</b> (appropriated revenues and projected expenses for one year –a 12-month period)	§12 VAC 35-46-20 (D)(1) §12 VAC 35-46-190 (A)(2)	§35-105-40(A)(1)
3. <input type="checkbox"/> <b>Evidence of financial resources</b> or line of credit sufficient to cover estimated operating expenses for ninety days (and must be maintained on an ongoing basis)	§12 VAC 35-46-180	§35-105-210(A) & §35-105-40(A)(2)
4. <input type="checkbox"/> A copy of the <b>Organizational Structure</b> , showing the relationship of the management and leadership to the service	§12 VAC 35-46-20 (D)(1) & §12 VAC 35-46-20 A	§35-105-190(B)
5. <input type="checkbox"/> <b>Complete Service Description</b> (including philosophy and objectives of the organization, comprehensive description of population to be served, admission, exclusion, continued stay, discharge/termination criteria, a description of services or interventions to be offered, brochures, pamphlets distributed to the public, a copy of the proposed program schedule, etc)	§12 VAC 35-46-20 (D)(1)	§35-105-40 & §580(C), §570
6. <input type="checkbox"/> <b>Record Management Policy</b> addressing all the requirements of the regulation	§12 VAC 35-46-20 B [1-5] §12 VAC 35-46-180. C	§35-105-40 & §870(A), 390
7. <input type="checkbox"/> <b>Staffing Schedule &amp; Written Staffing plan</b> (use staff information sheet to list potential staff members with designated positions & qualifications, etc.), relief staffing plan, & comprehensive supervision plan	§12 VAC 35-46-180	§35-105-590
8. <input type="checkbox"/> <b>Resumes of all</b> identified Staff, particularly services director, QIDP, QMHP, and licensed personnel.	§12 VAC 35-46-270 (B)(1)	§35-105-420(A)
9. <input type="checkbox"/> <b>Position Descriptions</b> - copies of <b>all</b> position(job) descriptions that address all the requirements (position descriptions for case management, ICT and PACT services must address the additional regulations for those services).	§12 VAC 35-46-20 (D)(1) §12 VAC 35-46-280, §12 VAC 35-46-340 & §12 VAC 35-46-350	§35-105-40 & §410(A)
10. <input type="checkbox"/> <b>Evidence of Authority</b> to conduct Business in Virginia. Generally this will a copy of the applicant's State Corporation Commission Certificate.	§12 VAC 35-46-20 (D)(1) & §12 VAC 35-46-320	§35-105-40(A)(3) and §190(B)
11. <input type="checkbox"/> <b>Certificate of Occupancy</b> – for the building where services are to be provided (except home-based services),	§12 VAC 35-46-20 (D)(1)	§35-105-260
<b><i>And for residential services:</i></b>		
1. <input type="checkbox"/> Copy of the Building floor plan, with dimensions	§12 VAC 35-46-20 (D)(1)	§35-105-40 (B)(5)
13. <input type="checkbox"/> Current Health Inspection	§12 VAC 35-46-20 B	§35-105-290
14. <input type="checkbox"/> Current Fire Inspection	§12 VAC 35-46-20 (D)[1-4]	§35-105-320
<b>Children's Residential Service Only</b>		
15. <input type="checkbox"/> Articles of Incorporation, By- laws, & Certificate of Incorporation	§12 VAC 35-46-20 (D)(1)	Facility operated by a <b>VA corporation</b>
16. <input type="checkbox"/> Articles of Incorporation, By- laws, & Certificate of Authority	§12 VAC 35-46-20 (D)(1)	Facility operated by a <b>out of state corporation</b>
6. <input type="checkbox"/> Listing of board members, the Executive Committee, or public agency all members of legally accountable governing body	§12 VAC 35-46-20-170	Facilities with a <b>Governing Board</b>
7. <input type="checkbox"/> References for three officers of the Board including President, Secretary and Member-at-Large	§12 VAC 35-46-20 D	Facility operated by <b>Corp., an unincorporated Organization, or an Association</b>

## Current/Past Provider Services

Please identify:

- 1) The legal names and dates of any services licensed in Virginia or other states that the applicant currently holds or has held,
- 2) Previous sanctions or negative actions against any licensed to provide services that the holds or has held in any other state or in Virginia, and
- 3) The names and dates of any disciplinary actions involving the applicant's current or past licensed services. If none, please indicate, "NONE" in the space below.

**Current Services:**

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**Past Services:**

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**Sanctions/Negative Actions/Disciplinary Actions:**

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## Certificate of Application

This certificate is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

*I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance if licensed.*

*I grant permission to authorized agents of the Department of Behavioral Health and Developmental Services to make necessary investigations into this application or complaints received.*

*I understand that unannounced visits will be made to determine continued compliance with regulations.*

**TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.**

Signature of Applicant: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

If you have any questions concerning the application, please contact this office at (804) 786-1747. Please return the completed application to:

**Office of Licensing  
Department of Behavioral Health and Developmental Services  
Post Office Box 1797  
Richmond, Virginia 23218-1797**