

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
1 DAVIS SQUARE, SUITE 101
CHARLESTON, WEST VIRGINIA 25301-1799

**INITIAL OR RENEWAL APPLICATION
FOR LICENSE TO PROVIDE
BEHAVIORAL HEALTH SERVICES**

INSTRUCTIONS: Please read carefully and complete this application in accordance with instructions (use computer, typewriter or print legibly with permanent types of ink).

- Application for license may be made by any political subdivision or by any person, association or corporation.
- Please complete a Page 3 for each building **owned or leased** by the applicant from which or in which behavioral health services are being provided. Please complete a separate page 3 for multiple buildings at the same address. **Please note:** If administrative office is indicated, please include services that will be provided.
- The application shall be verified before an officer of the State authorized to administer oaths, by the person, or by a member of the firm or association or an officer of the corporation making this application.
- This application must be accompanied by a check or money order payable to the West Virginia Department of Health and Human Resources in the amount of ten dollars (\$10.00).

NAME AND LOCATION

Name of Center/Agency: _____

Administrative Mailing Address: _____

Administrative Physical Location: _____

Telephone Number: _____ Fax Number: _____

FEIN#: _____ E-Mail Address: _____

(To be used for the licensure process)

MANAGEMENT AND PERSONNEL OF INSTITUTION

Give exact name of Individual, Partnership, Corporation or Organization Operating Center/Agency:

List Names and Addresses of Any Persons Who, as a Stock Holder or Otherwise, Have a Proprietary Interest of Five (5%) Percent or More in the Center/Agency:

Give Name of Governing Body (Board of Directors, Trustees, Etc.):

List Name and Address of Officers (with Titles) and Members of Governing Board:

	Name	Address	Title
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Give Name and Title of Center/Agency Director:

OWNED OR LEASED BUILDING/SERVICE PROVISIONS (If the Center does not own or lease the property, the Center can not license it.)
Name of Building:
Street Address:
City/State/Zip Code:
County:
Telephone Number:
Ownership of Building:
Type of Construction:
Number of Stories:
Gross Square Footage:
Is building sprinklered?
If 24 hour adult residential, are all consumers capable of self-preservation?

DISABILITY SERVED (check all that apply):
<input type="checkbox"/> Alcohol/Substance Abuse <input type="checkbox"/> Mental Illness/Behavioral Disorder <input type="checkbox"/> Mental Retardation/Developmental Disability (MR/DD)
AGE RANGE OF CONSUMERS SERVED (check all that apply):
<input type="checkbox"/> Children 2-17 <input type="checkbox"/> Adults 18+ <input type="checkbox"/> Adults 60+

TOTAL # OF CONSUMERS WHO RECEIVE SERVICES FROM THIS BUILDING [OPEN CASES/FILES ONLY]:

TYPE OF SERVICES PROVIDED [check only the service(s) provided in or out of this building]:
<input type="checkbox"/> Administrative Office <input type="checkbox"/> Outpatient Services <input type="checkbox"/> Day Treatment <input type="checkbox"/> MR/DD Waiver Services <input type="checkbox"/> 24 Hour Adult Residential Services

TYPE OF RESIDENTIAL SERVICE	NUMBER OF BEDS
Adult Group Home	
Public Inebriate Shelter	
Crisis Residential Unit	
Residential Substance Abuse	
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	
Other (please describe):	
TOTAL NUMBER OF BEDS IN THIS BUILDING:	

APPLICANT

_____, 20____

Signature of Individual/Administrative Officer:

Title or Position:

If other than Individual or Administrative Officer:

Name

Address

VERIFICATION

STATE OF WEST VIRGINIA)
) ss
County of _____)

_____, being by me duly sworn on his/her oath,
deposes and says that he/she has read the foregoing application and knows the contents thereof: that
the statements concerning the above named center/agency, therein contained, are correct and true of
his/her own knowledge.

(Signature of Individual/Administrative Officer)

Subscribed and sworn to before me this

_____ day of _____, 20_____.

Notary Public

My Commission expires: _____.