

**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**

<p style="margin:0">AMENDED APPLICATION FOR LICENSE TO PROVIDE BEHAVIORAL HEALTH SERVICES</p>
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INSTRUCTIONS:

Please read carefully and complete this application in accordance with instructions (use 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 4 for each new service provision or residential location/building operated by the applicant.

- 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:

**REQUESTED CHANGE TO CURRENT
BEHAVIORAL HEALTH CENTER LICENSE**

Please describe below requested change (or changes) to the current license, i.e., adding new service location/facility or a change in bed capacity. For any service change (or changes) as currently licensed, a Certification of Need (CON) or a decision of non-reviewability must be rendered from the Health Care Authority. Please indicate below the CON File number(s) and date(s) for any change(s).

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Please indicate below any service locations or facilities that are to be dropped from the Center's license.

If the change (or changes) is a service location or residential facility which is owned or leased by the Center, please complete a Page 4 for the service location/facility.

OWNED OR LEASED BUILDING/SERVICE PROVISIONS

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):

- Alcohol/Substance Abuse Mental Illness/Behavioral Disorder Mental Retardation/Developmental Disability (MR/DD)

AGE RANGE OF CONSUMERS SERVED (check all that apply):

- Children 2-17 Adults 18+ 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]:

- Administrative Office Outpatient Services Day Treatment MR/DD Waiver Services 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 (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 _____.