## Application for License to Operate a Behavioral Health Services Organization OIG 20:430 – October 2019

ı.	Type of	Application:							
	Initial Licensure Application (\$750 Fee) Renewal Application (\$500 Fee) Adding an Extension Location (\$250 Fee)			Change	Change of Ownership (\$750 Fee) Change of Location (\$100 Fee) Change of Name (\$25 Fee), Effective Date:				
II.									
	Screening Assessment Psychological Testing Crisis Intervention Mobile Crisis Services Day Treatment Peer Support Intensive Outpatient Program Services Individual Outpatient Therapy Group Outpatient Therapy Family Outpatient Therapy Collateral Outpatient Therapy			Asserti Disordo Screen Treatm Compr Therap Serious Disabili Targeto	Service Planning Assertive Community Treatment for Mental Health Disorders  Screening, Brief Intervention and Referral to Treatment for Substance Use Disorders Comprehensive Community Support Services Therapeutic Rehabilitation Program for an Adult with a Serious Mental Illness or Child with a Severe Emotional Disability Targeted Case Management Services Partial Hospitalization				
				HOURS OF OPERA	TION				
r	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday		
III. IDENTIFICATION:									
License Number: (Not applicable if this is an application for initial licensure)									
Name:									
Physical Location of Facility:(Street)						(City)			
		((	County)		(State)	(Zip Code)			
Mailing Address: (If different from above)			(Street)		(City)				
(County Telephone Number:				ounty)	(Stat	e)	(Zip Code)		
reieh	none munik								

(Primary contact for correspondence)

Email Address:

Name of Executive Director:								
Date facility began operating at current address:								
Date facility began operating under current owner:								
IV.	Extension Locations:							
	Number of Extensions:							
	If there are no extensions, skip to next section. If reporting the name of each extension as part of the application for initial licensure or adding a new extension, please complete this section.							
	Name of Extension:							
	Physical Location of Extension:(Street) (City)							
			(County)	(State)	(Zip Code)			
	Telephone number:  Extension Director's Name and Email Address:							
V.	with the name,							
	State	eck one in each c	Profit	Indiv	idual			
	County City Private		Nonprofit		nership oration			
VI. OWNERSHIP Name and address of direct owner								

NOTE: Provide the following supporting documentation as an attachment to this application:

- The of name, mailing address, email address and phone number each person having at least a twenty-five (25) percent ownership interest in the facility;
- If owned by a corporation, the name, mailing address, email address and phone number of each officer or director of the corporation;
- If owned by a partnership, the name, mailing address, email address and phone number of each partner.

## VII. FIRE MARSHAL (FOR INITIAL, ADDITIONAL EXTENSIONS, AND CHANGE OF LOCATION APPLICATIONS.)

Please submit documentation of the Fire Marshal's approval for the location(s) where services will be provided. Final approval from the Fire Marshal shall be considered current if approved within 12 months from the date the Office of Inspector General receives the licensure application. If your facility has not been inspected and approved within the previous 12 months, please contact the Fire Marshal's Office to request an inspection.

An incomplete application or failure to submit the applicable licensure fee may result in return of the application to the applicant. A completed application should not be submitted to the Office of Inspector General until the facility is ready for an inspection.

I understand that any change in the information provided within this application which affects the licensure status of this service will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation allow state agency licensing personnel to enter the facility for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and I recognize that falsification of this application may result in denial or revocation of licensure.

Signature of Authorized Representative	Title	Date
Submit the application, <b>fee*, proof of accredit</b>	ation**, and any attachmen	ts to:
Office of Inspector General Division of Health Care 275 East Main Street, 5E-A Frankfort, Kentucky 40621		
*For each extension location, add \$250 per extens change of ownership and \$500 for annual renewal		s \$750 for initial licensure or
**Unless an extension is granted, Behavioral Heal of initial licensure by the Joint Commission, Comm Accreditation, or other nationally recognized accre annually for renewal of licensure.	nission on Accreditation of Reh	abilitation Facilities, Council on
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