

STAFF ROSTER

FULL NAME _____ TITLE _____ DATE OF BIRTH _____
EDUCATION/DEGREE _____ LICENSE/CERTIFICTION _____
SUPERVISOR _____ TITLE _____

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APPLICATION FOR – MENTAL HEALTH AGENCY

SERVICES BEING APPLIED FOR:

(Include Module Type, Specific Service, and each location from which service will be delivered, number of clients, age range, and gender. (Attach additional sheets if necessary).

MODULE: _____ SERVICE: _____ # OF CLIENTS: _____
AGE RANGE: _____ GENDER: _____
LOCATION ADDRESS: _____

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FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM

Type of License/Certification: _____

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one form for each site from which you plan to deliver services and return with your application. (ONE FORM FOR EACH SITE)

2. All Applicants: Complete and submit form when you are adding a site, changing your address, or closing a site.

MAIN SITE:

Agency Name: _____ Date: _____

Operator/Exec. Director: _____ Phone: _____

Address: _____ Contact Person (If different) _____

(City, State, Zip)

Phone: _____

DESCRIPTION OF SERVICES: _____

AGE RANGE OF CLIENTS SERVED: _____ **MAXIMUM CAPACITY:** _____

RESIDENTIAL: _____ **NON-RESIDENTIAL:** _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____

COMPLETE ONLY IF CHANGE:

New Program/Agency In Process of Licensure _____

Closing Existing Site _____ Address: _____

Adding New Site _____ Address _____

Moving Office Site Within Same Building _____

NEW SITE: Date of Expected Move: _____

Contact Person: _____ Phone: _____

WATER SOURCE: Municipal _____ Well _____ Other _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____

WAIVER / EXCEPTION REQUEST OR RE-REQUEST (If applicable)

I/We have received and read the rules for the licensing process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshall's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office. I/We understand any falsification of statements may be grounds for denial.

I/We further certify that all information contained in this application (including addendum) is complete and accurate.

SIGNATURE REQUIRED:

Applicant/Operator/Administrator

DATE: _____

Type or Print Name

Board President

DATE: _____

Type or Print Name

ALL APPLICANTS PLEASE SUBMIT:

1. Completed application
2. **\$25 Fee – Make check payable to: TREASURER, STATE OF MAINE**
3. Organizational Chart
4. List of Governing Body Members/Offices Held/Addresses
5. Fire Inspection Form (New Sites)
6. Staff Roster
7. ADA Self-Evaluation Form (New Sites)
8. Program Descriptions
9. Program Admission criteria for each program
10. Any new or changed policies
11. Submit current water test for each site not on public water

FIRST TIME APPLICANTS ALSO MUST SUBMIT:

1. Articles of Incorporation
2. Complete Policy and Procedure Manual
3. Sample Client File
4. Equal Opportunity Questionnaire & Documentation

SUBMIT APPLICATION TO:

**Department of Health and Human Services
Cathy Parlin
Community Services Programs
11 State House Station, 41 Anthony Ave.
Augusta, ME 04333**

Phone: (207) 287-4399

Fax: (207) 287-9252

TTY: (800) 606-0215