



**STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES**

**Behavioral Health Program
Alcohol and Drug Treatment Program Application**

SECTION 1: Facility Information			
Facility/Agency Name:			
Physical Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ()		Fax No.: ()	
Email Address:		State Tax ID or Employer ID No.:	

SECTION 2: Fees	
APPLICATION FOR ALCOHOL AND DRUG TREATMENT PROGRAM	
License Type (Select all that apply):	
<input type="checkbox"/> New License (fee \$50) <input type="checkbox"/> Renewal License (fee \$50)	
Total Fee Enclosed for application	\$ <u>50.00</u>
<input type="checkbox"/> Add a Service & Renewal (fee \$50.00 x # of services: _____)	
<input type="checkbox"/> Detox, Medical Model <input type="checkbox"/> Detox, Social Setting <input type="checkbox"/> Shelter	
<input type="checkbox"/> Extended Shelter <input type="checkbox"/> Assisted, Medical Model <input type="checkbox"/> Extended Care Residential Rehab	
<input type="checkbox"/> Halfway House <input type="checkbox"/> Outpatient Care <input type="checkbox"/> Non-Residential Rehab	
<input type="checkbox"/> Methadone Treatment <input type="checkbox"/> DEEP-Driver Ed. Evaluation Program	
Total Fee Enclosed for adding a service(s)	\$ _____
<input type="checkbox"/> Add a Site (fee \$25 x # of new sites: _____)	
Total Fee Enclosed for adding a site(s)	\$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash.	\$ _____
Credit Cards are not accepted at this time. Total Check/Money Order Enclosed: =	\$ _____

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Behavioral Health Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-4399 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: info.dhhs@maine.gov

<i>Office Use Only:</i>
Check# _____ MO # _____ Amount \$ _____ Initials: _____ License# _____

SECTION 3: Facility Contact Information			
Name and Title of Primary Contact Person:			
Telephone No.: ()		Email Address:	
Name and Title of Administrator/Operator:			
Telephone No.: ()		Email Address:	
Name and Title of Executive Director:			
Telephone No.: ()		Email Address:	
Corporation Name (if applicable):			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ()		Fax No.: ()	

SECTION 4: Facility Information														
<p>Accreditation:</p> <p>Is the facility accredited?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, Please indicate which accrediting agency: _____</p> <p>How many years has the facility held this accreditation? _____</p>														
<p>Type of facility:</p> <p><input type="checkbox"/> Individual Proprietorship <input type="checkbox"/> Non-Profit Corporation <input type="checkbox"/> Tribal Government</p> <p><input type="checkbox"/> Church <input type="checkbox"/> Partnership <input type="checkbox"/> Parent Co-Op</p> <p><input type="checkbox"/> Other (describe): _____</p>														
<p>Services:</p> <p><input type="checkbox"/> License (Residential Treatment Program)</p> <p><input type="checkbox"/> Certificate of Approval (Non-Residential Treatment Program)</p> <p>Catchment Area: (Geographic Area Served) _____</p> <p>Residential License: (Check each component to be reviewed)</p> <table> <tr> <td><input type="checkbox"/> Detox, Medical Model</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Detox, Social Setting</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Shelter</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Extended Shelter</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Assisted, Medical Model</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Extended Care Residential Rehab</td> <td>Number of Beds: _____</td> </tr> <tr> <td><input type="checkbox"/> Halfway House</td> <td>Number of Beds: _____</td> </tr> </table>	<input type="checkbox"/> Detox, Medical Model	Number of Beds: _____	<input type="checkbox"/> Detox, Social Setting	Number of Beds: _____	<input type="checkbox"/> Shelter	Number of Beds: _____	<input type="checkbox"/> Extended Shelter	Number of Beds: _____	<input type="checkbox"/> Assisted, Medical Model	Number of Beds: _____	<input type="checkbox"/> Extended Care Residential Rehab	Number of Beds: _____	<input type="checkbox"/> Halfway House	Number of Beds: _____
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<input type="checkbox"/> Extended Care Residential Rehab	Number of Beds: _____													
<input type="checkbox"/> Halfway House	Number of Beds: _____													
<p>Waiver Request: If you are requesting a new waiver/exception or an extension, please describe your request:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>														

SECTION 5: Staff Roster

Complete the following information. Use additional paper if necessary.

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

Full Name:	Title:	Date of Birth:
Education/Degree:	License/Certification:	
Supervisor:	Supervisor's Title:	

SECTION 6: Services being applied for

Complete the following information. Use additional paper if necessary.

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

Module Type:		Service:	
Age Range:	Gender:	Number of Clients:	
Address:			

SECTION 7: Submission

Remember to submit the following documents with your completed application:

- A check or money order made payable to “Treasurer, State of Maine”
- Fire Inspection Form (Required for ALL new sites) - Appendix A
- Organizational Chart
- List of Governing Body Members/Offices held/Addresses
- Staff roster
- Program descriptions
- Program admission criteria for each program
- Any new or changed policies
- Submit current water test for each site not on public water

In addition, first time applicants must also submit:

- Articles of Incorporation
- Assurance of Compliance (ADA/EEO)
- Complete Policy and Procedures Manual
- Sample client file

SECTION 8: Declaration

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 Marshal’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 statement may be grounds for denial.

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

Print name of Applicant/Operator/Administrator	Signature of Applicant/Operator/Administrator	Date
Print name of 2nd Applicant (If Applicable)	Signature of 2nd Applicant (If Applicable)	Date
Print name of Board President (If Applicable)	Signature of Board President (If Applicable)	Date

Fire Inspection Request and Address Change Form**Type of License: ALCOHOL AND SUBSTANCE ABUSE****Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.**

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one (1) form for each site from which you plan to deliver services and return with your application. (Complete a separate form for each site).
2. All Applicants: Complete and submit form when you are adding a new site, changing your address, or closing a site. (Retain a copy of this form for your records).

MAIN SITE:

Agency Name: _____ Date: _____

Operator/Executive Director: _____ Telephone: _____

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:**Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.**New Program/Agency In Process of Licensure: No Yes, date of submitted application: _____ Closing Existing Site Current Address: _____

 Moving Office Site within Same Building _____ Adding New Site New Address: _____

Date of Expected Move: _____

Contact Person: _____ Telephone: _____

Water Source: Municipal Well Other: _____

Directions to Facility: (Be specific with known landmarks.) _____
