



**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	
<p>License Type:</p> <p><input type="checkbox"/> New License (fee \$50) <input type="checkbox"/> Renewal License (fee \$50) - Current License # _____</p> <p style="text-align: right;">Total Fee Enclosed for License \$ <u>50.00</u></p> <p>Module(s) (fee \$25.00 x # of Modules checked below: _____)</p> <p><input type="checkbox"/> Outpatient Care <input type="checkbox"/> Inpatient Care <input type="checkbox"/> Residential Programs</p> <p><input type="checkbox"/> Non-Residential Programs <input type="checkbox"/> DEEP</p> <p style="text-align: right;">Total Fee Enclosed for Module(s) \$ _____</p> <p><input type="checkbox"/> Add a Site or <input type="checkbox"/> Renew a Site (fee \$25 x # of Sites: _____)</p> <p><input type="checkbox"/> School is \$10.00 per Site (fee \$10 x # of Sites: _____)</p> <p style="text-align: right;">Total Fee Enclosed for Site(s) \$ _____</p>	<p>Total Check/Money Order Enclosed:</p> <p>\$ _____</p>
<p>Make check or money order payable to "Treasurer, State of Maine." Do not send cash. Credit Cards are not accepted at this time.</p>	

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

Office Use Only:				
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**Accreditation:**

Is the facility accredited?

- No
- Yes, Please indicate which accrediting agency: _____
- How many years has the facility held this accreditation? _____

Type of facility:

- Individual Proprietorship Non-Profit Corporation Tribal Government
- Church Partnership Parent Co-Op
- Other (describe): _____

Geographic Area Served: _____

Residential License (check each service provided):

Residential Program**Number of Beds****Inpatient Care****Number of Beds**

- | | | | |
|--|-------|---------------------------|-------|
| <input type="checkbox"/> Assisted, Medical Model | _____ | Detox, Medical Model | _____ |
| <input type="checkbox"/> Detox, Social Setting | _____ | Intensive Inpatient Detox | _____ |
| <input type="checkbox"/> Extended Care Residential Rehab | _____ | | |
| <input type="checkbox"/> Extended Shelter | _____ | | |
| <input type="checkbox"/> Halfway House | _____ | | |
| <input type="checkbox"/> Residential Rehabilitation | _____ | | |
| <input type="checkbox"/> Shelter | _____ | | |

Requests: If you are requesting a waiver/exception/extension, please describe below:

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:			

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Age Range:	Gender:	Number of Clients:	
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Age Range:	Gender:	Number of Clients:	
Address:			

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Address:			

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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
- ADA Self-Evaluation Form (new sites only)
- 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 visits and inspections as needed 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 concerning named on application. 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): _____

_____ Phone: _____

(City, State, Zip)

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.) _____
