

**Commonwealth of Massachusetts**

**Department of Mental Health**

**Community Crisis Stabilization Services**

**Application For Licensure**

**Application Type:**

* [ ] - Initial
* [ ]  - Renewal

Please complete this application for Licensure. ***All attachments should be labeled and identified by the corresponding question.***A description of the survey process is included in the email sent to the provider with the date of the survey and will also be available on our website.

Applications should be submitted to your identified DMH Contact/Licensing Coordinator.

**I. Applicant Information**

1. Primary Provider Entity Name:

Primary Provider Entity Address (street/city or town/zip code):

1. Chief Executive Officer/President Name:  Title:

 Office Telephone: Fax:

Email Address:

1. If subcontract, please complete:

Community Behavioral Health Center (CBHC) Agency:

 CBHC Address (street/city or town/zip code):

1. Please list name, title, telephone number and email address of key staff that can assist in matters

 related to the application for licensure. This should include person in charge (PIC), designee,

 licensing liaison, and contact for scheduling, if applicable.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **Phone** | **Email** | **Identify role: PIC/Designee/Licensing Liaison/Contact to Schedule** |
|       |       |       |       |       |
|       |       |       |       |       |
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**II. Service/Facility Information**

1. DMH License Class Requested (see 104 CMR 28.15)

Class I [ ]

Class II [ ]

Class III [ ]

1. Program Name:

Program Address (street/city or town/zip code):

1. Certifications/Licenses

 Please submit the *most recent* certifications/licenses or explanation for the following:

|  |  |  |
| --- | --- | --- |
| **Certificate/License** | **Expiration****Date** | **If not available, provide explanation** |
| Local Fire Inspection |       |       |
| Local Building Inspection |       |       |
| Certificate of Occupancy |       |       |
| Other  |       |       |
|  |       |       |

1. Please submit floor plan for CCS Unit, to include: (1) square footage of each room and it’s

 proposed use, (2) location of windows, (3) exit way routes and means of egress.

 If co-located in CBHC, please provide building floor plan, if available.

1. Staffing

Please submit a listing of all staff by name, degree/credentials, title, FTE, date of hire, license number

and expiration date (as appropriate). Use format below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Degree/****credentials** | **Job Position** | **FTE**  | **Date of Hire** | **License****Number** | **License** **Expiration Date** |
| Mary Smith | M.D. | Medical Director | .75 | 10/1/12 | #02456 | 10/4/18 |
| John Doe | LICSW | Clinical Program Director | 1.0 | 2/14/16 | #9521 | 11/25/18 |
|  |  |  |  |  |  |  |

 Include schedule if available at time of application.

1. Waiver Petitions

Does the Applicant intend to petition the Department of Mental Health for a waiver or waiver renewal? Yes [ ]  No [ ]

If “Yes”, completed waiver petition(s) should be included with this application.

1. Legal Proceedings

Has the Applicant or any of its employees been the subject to any legal proceedings (suits, investigations etc.) related to the provision of services or that would impact the provider’s ability to provide such services?

 Yes [ ]  No [ ]

 If “Yes”, please attach summary and outcome of proceedings.

1. Certification

I certify that all the information contained herein is correct and complete. I will provide any information to the Department that may be required under statute or regulation for the purpose of licensure.

* Further, I hereby certify, on behalf of the Applicant, that the Applicant will undertake to fully comply with all DMH requirements in **104 CMR 28.00.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Signature of President/CEO or Designee Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Type or Print Name Title

Applicant’s Name:

 Provider Agency