**Commonwealth of Massachusetts**



**Department of Mental Health**

**Application For Licensure/ Renewal/ Certification**

**DMH Area:** **Central** **Metro Boston** **Northeast Southeast West**

**I. Applicant Information** (Please Type All Responses)

A. Applicant’s Name(s):

B. Office Address:

Street Town Zip Code

C. Executive Director’s Name:  Title:

Office Telephone: Fax:

Area Code/Phone Number Area Code/Phone Number

Email Address:

D. Licensing Liaison Name: Title:

Mailing Address:

Street Town Zip Code

Office Telephone: Fax:

Area Code/Phone Number Area Code/Phone Number

Email Address:

**DMH Contract/Service Information**

E. Enter the Department of Mental Health Contract Number:

Or Not Applicable: State-operated Private Residential Program

Enter DMH Service Code from list () Other:

Name of Service:

Office Address:

Street Town Zip Code

F. Name of Director:  Title:

Mailing Address:

Street Town Zip Code

Office Telephone: Fax:

Area Code/Phone Number Area Code/Phone Number

Email Address:

**II. Residential Site Information**

A. If the Applicant has or intends to register a site with the Dept. of Public Health for administration of medications and storage of controlled substances, list below each site location and, if known, specify the Massachusetts Controlled Substance Registration (MCSR) # and expiration.

|  |  |  |  |
| --- | --- | --- | --- |
| **Street Address/Unit #** | **Town** | **MCSR #** | **Expiration Date** |
|  |  |  |  |

B. Does the Applicant receive funding for the service or residential site from sources other than the Department of Mental Health?

N/A Private Program  No  Yes If “Yes”, list the site location and source of funding:

|  |  |  |
| --- | --- | --- |
| **Street Address/Unit #** | **Town** | **Source** |
|  |  |  |

C. **Appendix A**

DMH Contracted or Operated

Complete **Appendix A** for all residential sites under a single DMH contract or for State-operated the single DMH Site for which a license is being sought. Identify by each residential unit: the street address, unit number, town, number people occupying and their self-preservation classification, staff and office location, ownership of building, type of lease arrangement, and if any, type of housing subsidy.

Private Residential Program

Complete an **Application** and **Appendix A and B** for each residential program.

D. **Appendix B**

Complete **Appendix B** for each residential site included in Appendix A that has on-site staffing.

**III. Floor Plan of Residential Site**

If a floor plan is required for a residential site(s) please attach to application.

**IV. Waivers**

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

If “Yes”, completed waiver petitions should be included with this application.

**V.** **Legal Proceedings**

Has the Applicant or any of its employees been the subject to any legal proceedings (suits, investigations, including DMH investigations) 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.

VI. **Policies and Procedures**

Has the Applicant added or revised any written policy and procedure relative to 104 CMR 28:00, 104 CMR 30.02: Client Funds in Community Programs, or 104 CMR 30.07: Disposition of Personal Property Abandoned at Facilities or Programs since the last Application?

Yes  No  N/A  (For Initial Application)

If yes, please list these below and attach copies with this Application.

|  |  |  |
| --- | --- | --- |
| Policy/Procedure Title | Effective Date | Indicate if New or Revised |
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**VII. 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 Executive Director or Designee Date

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

Type or Print Name Title

Applicant’s Name:

Provider Agency

Above Certification is being submitted as part of:

Initial Application

Renewal Application – due 90 days prior to license expiration

Appendix update to Application for a new residential site

Enter DMH Contract #

Not Applicable:  State-operated  Private Program

Attach **Appendix A**, and if applicable, **Appendix B** with floor plans, staffing schedule and occupancy/building permit(s).

**Appendix A**

Applicant’s Name: Date: If Applicable, DMH Contract #

| **Residential Sites**  **Street /Unit # /Town**  **Enter Each Unit on a**  **Separate Line** | **License #**  **(if any)** | **License Exp. Date** | **# of Persons** | **Self-Preservation Classification**  **(# of persons)** | | | **✓ If Unit has staffing /staff office on site** | **✓ If Unit is Owned by Applicant or Applicant’s Sub-contractor** | **Lease Holder**  **✓applicable box** | | **Identify Housing Subsidy or Resource**   1. **ATARP - DMH Contract Sponsor Based** 2. **Chapter 689/167** 3. **CHOICE** 4. **DMH Contract - Operations** 5. **DMH Contract – Rent for Individual** 6. **DMH Rental Subsidy – Provider Leased** 7. **DMH Rental Subsidy - Tenant Based** 8. **HUD 811 – Project Based** 9. **HUD 811 – Tenant Based** 10. **Project Based Section 8** 11. **Shelter Plus Care** 12. **State Property** 13. **Tenant Based Section 8** 14. **Other, specify (see instructions)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | Unimpaired | Partially Impaired | Impaired |  |  | Provider | Joint Provider with person |  |
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**Appendix B**

Applicant’s Name: Date: If Applicable, DMH Contract #

A. Residential Site Name:

B. Address of Residential Site with on-site staffing:

Street Town Zip Code

Mailing Address (if different)

Street Town Zip Code

C. Site Telephone:  Fax:

Area Code/Phone Number Area Code/Phone Number

D. Program Director: Title:

Email Address:

E. Is this Application for a site that has been relocated from a previously licensed site or had previously applied for licensure?

Yes  No  If “Yes”, Previous Address/Town:

F. Is this application for a site that has been operated previously by another provider agency?

Yes  No  If “Yes”, Previous Provider Name:

G. If the site is not a DMH contacted or operated Respite Program, does the residential site provide respite beds?

Yes  No  If “Yes”, define number:

1. Has occupancy permit or local building official certification been granted for the program site(s)?

**Note: Occupancy permit capacity number must include on-site respite beds, if any.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes, copy attached |  | Other (explain) |
|  | Applied for but not yet granted |  | Not applicable (explain) |

I. Does the site have the capacity to serve one or more persons with disabilities? Yes  No

Program Site Accessibility:

|  |  |
| --- | --- |
|  | Completely accessible to the mobility impaired person. (entrance, bathroom, bedroom, kitchen, dining, living, meeting and laundry rooms) |
|  | In part accessible, explain: |
|  | Not accessible |

Do the emergency warning systems include both audible alarms and visual alarms? Yes  No

J. Maximum client capacity: Anticipated date of full client capacity:

K. Does the Applicant control occupancy of this residential site? Yes  No

L.1. Include total number of staff stated in full-time equivalency: . If not known, please project.

2. Attach a site specific staffing schedule with position title and name, Include vacant positions.

3. Check one box to best describe daily staffing hours on site when clients are home:

|  |  |
| --- | --- |
|  | 24 hours per day |
|  | 18 to 24 hours per day |
|  | 15 to 18 hours per day |
|  | 8 to 15 hours per day |
|  | Less than 8 hours per day |