Addictive and Mental Disorder Division – Chemical Dependency Bureau
100 North Park Ave. Suite 300, PO Box 202905
Helena MT 59620-2905

CHEMICAL DEPENDENCY TREATMENT SERVICES
STATE APPROVAL APPLICATION

Applicant Information:

Applicant Name: _____

Mailing Address: _____

Physical Address: _____

City: _____ State/Zip: _____

Applicant Telephone Number: _____ FAX: _____

Applicant E-mail/Web Page Address: _____

Applicant Administrator: _____

Indicate type of service to be State Approved (mark all that apply)

- ☐ Day Treatment
- ☐ Detox
- ☐ Inpatient Treatment
- ☐ Adolescent Male Recovery Home
- ☐ Adolescent Female Recovery Home
- ☐ Parent and Children Home Recovery Home
- ☐ Adult Male Recovery Home
- ☐ Adult Female Recovery Home
- ☐ Adult Intensive Outpatient
- ☐ Adolescent Intensive Outpatient
- ☐ Adult Outpatient
- ☐ Adolescent Outpatient
- ☐ Educational Course – DUI/MDD
- ☐ Educational Course – MIP

Proposed Service Area

Provide a list of each county where the Applicant proposes to provide chemical dependency treatment services under this State Approval application.

County: _____

County: _____

County: _____

County: _____

County: _____

Please include the following with the application:

- **List names, professional license numbers and FTE designation of all licensed professionals employed by Applicant who will be providing chemical dependency treatment services for which the Applicant seeks State Approval.**
- **Organizational Chart – include Name and Title of Position**
- **Board of Directors – include name, position, address, email, and telephone number**
- **List of all Applicant site addresses and phone numbers**
- **Applicant's Policy and Procedures addressing Administrative Rules of Montana (ARM) 37.27.101 through 37.27.926, Code of Federal Regulations (CFR) 42 CFR Part 2 – Confidentiality, and 45 CFR Part 96 Targeted Populations (3 Hard copies)**
- **Copy of Health Care Facility License for inpatient/residential programs**
- **Documentation demonstrating local need *for each county* in application (see application supplement)**
- **Projected services form *for each county* in application (see application supplement)**
- **Documentation of non-duplication of services *for each county* in application (see application supplement)**

I certify that all information I have submitted to DPHHS is true and correct. This Application for a Chemical Dependency Treatment Services State Approval is hereby submitted under the provision of Section 53-24-101 through 53-24-306.

I understand the application and possible issuance of a Certificate of State Approval for Chemical Dependency Treatment Services does not entitle any facility listed in this application to a contract for services or other funding available for chemical dependency treatment services.

Signature: _____ **Date:** _____

Printed Name: _____

Title: _____

Address: _____ **City:** _____ **State/Zip:** _____