



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)

- | | |
|--|--|
| <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Adult Intensive Outpatient |
| <input type="checkbox"/> Detox | <input type="checkbox"/> Adolescent Intensive Outpatient |
| <input type="checkbox"/> Inpatient Treatment | <input type="checkbox"/> Adult Outpatient |
| <input type="checkbox"/> Adolescent Male Recovery Home | <input type="checkbox"/> Adolescent Outpatient |
| <input type="checkbox"/> Adolescent Female Recovery Home | <input type="checkbox"/> Educational Course – DUI/MDD |
| <input type="checkbox"/> Parent and Children Recovery Home | <input type="checkbox"/> Educational Course – MIP |
| <input type="checkbox"/> Adult Male Recovery Home | |
| <input type="checkbox"/> Adult Female Recovery Home | |

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)

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: _____