

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division - Licensure Bureau

2401 Colonial Drive - 2nd Floor

P.O. Box 202953

Helena, MT 59620-2953

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
MENTAL HEALTH CENTER**

Initial Application **Renewal** **Adding or Changing Endorsements***
(complete page 1 and 2 if adding or changing endorsements)

ORGANIZATION NAME _____

ADMINISTRATIVE OFFICE ADDRESS _____

CITY _____ COUNTY _____

ADMINISTRATIVE OFFICE TELEPHONE NUMBER _____

Name of Applicant/Administrator _____

Administrator Address _____

Name of Chairman of Board (if any) _____

Information on ownership, contract, or lease agreement if operated by a person other than the owner:

- A partnership, firm or association--list every member thereof.**
- A corporation--list the name and address thereof and the names of its officers.**
- State Affiliated Organization**

| Name | Address |
|------|---------|
| | |
| | |
| | |
| | |
| | |

(please attach additional sheets if necessary)

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division - Licensure Bureau

List the name and professional license number of the Mental Health Center's medical director.

Name _____ License No _____

List names and professional license numbers of all licensed professionals employed by your Organization.

| NAME | LICENSE NO. |
|-------|-------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Check the areas of endorsement for which your organization is requesting licensure, (ARM 37.106.1906):

- Child and Adolescent Intensive Case Management
- Adult Intensive Case Management
- Child and Adolescent Day Treatment
- Adult Day Treatment Program
- Foster Care for Adults with Mental Illness
- Comprehensive School and Community Treatment Program (CSCT)
- Inpatient Crisis Stabilization Program
- Mental Health Group Home
- Outpatient Crisis Response Facility
- Secured Crisis Stabilization Facility (SCSF)
- Forensic Mental Health Facility (FMHF)

Please include the following with your application:

- **For Inpatient Crisis Stabilization Program, Mental Health Group Home, Outpatient Crisis Response Facility, Secured Crisis Stabilization Facility and Forensic Mental Health Facility: provide a list with the name, address, phone number, name of supervisor, and the number of beds for each facility.**
- **For Child and Adolescent Intensive Case Management, Adult Intensive Case Management, Child and Adolescent Day Treatment, Adult Day Treatment Program, Foster Care for Adults with Mental Illness, Comprehensive School and Community Treatment Program (CSCT): provide a list of all individual site addresses.**
- **Mental Health Center Policies and Procedures (only required at the time of initial application or upon addition of a new endorsement)**

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division - Licensure Bureau

I certify that all information submitted to DPHHS is true and correct. This license application for a Mental Health Center is hereby submitted under the provisions of Section 50-5-101 through 50-5-231, MCA.

DATE _____ SIGNED _____

TITLE _____

ADDRESS _____

Please enclose a check, money order or draft made payable to the Department of Public Health and Human Services to cover the license fee. The fee is determined as follows:

- (a) facilities with 20 beds or less -- \$20.00;
- (b) facilities with 21 beds or more -- \$1.00 per bed;
- (c) facilities with no beds -- \$20.00.

This fee will be deposited in the State Treasury and is non-refundable.