

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division – Licensure Bureau
2401 Colonial Drive, PO Box 202953
Helena MT 59620-2953
FAX: (406) 444-1742

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
CHEMICAL DEPENDENCY LICENSE APPLICATION**

Initial Application

Renewal Application

Indicate type of service being licensed:

INPATIENT CHEMICAL DEPENDENCY FACILITY _____

____ 3.7 Inpatient [] No. Beds _____
____ 3.7 Inpatient Detox [] Detox No. Beds _____
____ 3.5 Inpatient Residential Services Program [] No. Beds _____

*Serving: Adults [] Adolescents []
If serving both must be in separate unit.*

RESIDENTIAL CHEMICAL DEPENDENCY FACILITY _____

____ III.1 Halfway House Community-Based Single Gender Residential Home, Low Intensity Treatment
____ III.3 Halfway House Community-Based Single Gender Residential Home, Medium Intensity Treatment
____ III.3 Halfway House Community-Based Parent and Children Residential Home, High Intensity Treatment
____ III.5 Halfway Home Single Gender Residential Home, High Intensity Treatment

No. Beds _____

*Serving: Adults [] Adolescents []
If serving both must be in separate unit.*

Facility Name: _____

Facility Address: _____ PO Box: _____

City _____ Zip _____ County _____

Facility Telephone Number: _____ FAX: _____

Facility E-mail/Web page Address: _____

Name of Applicant: _____

Applicant Address: _____

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City _____ State/Zip _____

Applicant (or contact) e-mail address: _____

Administrator of Facility: _____

Owner (If different from Applicant): _____

Owner Address: _____ City _____ State/Zip _____

Floor Plan is: New Construction Existing Structure Addition Remodeled

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

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

NAME

ADDRESS

(Please attach additional sheets as needed.)

List name, type of profession and license number of all licensed professionals employed by your Facility:

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NAME	LICENSE TYPE	LICENSE NO.

(Please attach additional sheets as needed.)

I certify that all information I have submitted to DPHHS is true and correct. this Application for a Chemical Dependency License is hereby submitted under the provision of Section 50-5-101 through 50-5-208.

SIGNED _____ **DATE** _____
TITLE _____
ADDRESS: _____ **CITY** _____ **STATE/ZIP** _____

Enclose a check, money order or draft made payable to the *Department of Public Health & Human Services* to cover the license fee. The fee is determined as follows:
(a) facilities with 20 or less = \$20.00
(b) facilities with 21 beds or more = \$1.00 per bed.
This fee will be deposited in the State Treasury and is non-refundable.