

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division-Licensure Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620

Specialty Mental Health Facility
Application for Montana State Health Care Facility/Service License (Page 1 of 2)

ORGANIZATION NAME _____

ADMINISTRATIVE OFFICE ADDRESS _____

CITY _____ COUNTY _____

ADMINISTRATIVE OFFICE TELEPHONE NUMBER _____

NAME OF APPLICANT _____

APPLICANT ADDRESS _____

Application for license to conduct a Specialty Mental Health Facility is hereby submitted under the provisions of Section 50-5-101 through 50-5-231, MCA.

The following information is required with this form to process your application for a Specialty Mental Health Facility License.

1. Designated name and location of Specialty Mental Health Facility
2. 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.
3. List the number of employees in all job classifications.
4. List names and professional license numbers of all licensed professionals employed by your organization.
5. List the number and type of patients or residents for which care is provided.
6. Facility plans and specifications including the number and the location of beds.
7. Notice of contracts and/or agreements with other facilities or licensed professionals that may combine to provide the services with the Specialty Mental Health Facility
8. Specialty Mental Health Facility Policies and Procedures

If the facility is owned by anyone other than the applicant, attach a copy of rental agreement or lease showing consent to operate a Specialty Mental Health Facility and the responsibility for maintaining the facility in accordance with the minimum standards established by the State Department of Public Health and Human Services and Montana Licensing Law.

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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.

Owner of building and grounds is _____

Name of Administrator _____

Name of Chairman of Board (if any) _____

DATE _____ SIGNED _____

TITLE _____

ADDRESS _____
