Application For Licensure To Provide SUBSTANCE USE SERVICES

Submission Date (Month/Day/Year)

☐ New Application
☐ Renewal
☐ Relocation
Anticipated Relocation Date:
☐ Change in Organization

I. SERVICE PROVIDER INFORMATION

1. Service Provider Legal Name (if multiple locations, enter CORPORATE HEADQUARTERS name)	2. Federal ID #	3. National Provider ID (NPI)

4. Name of the Service Provider's Owner	5. Corporate Website Address

6. Corporate / Owner's Mailing Address			
6a. City	6b. State	6c. Zip Code	6d. County

7. Circuit/Region	8. Telephone (Area Code & Number)	9. Fax Telephone (Area Code and Number)

10. Physical Address (If different from mailing address)			
10a. City	10b. State	10c. Zip Code	10d. County

11. Is the applicant accredited by a certifying organization approved by the department? If so, please include the accrediting organization's information below:

Name of Accrediting Organization:_____

☐ Three-Year ☐ One-Year Accreditation Expiration Date:_____

For renewals, please submit the most recent accreditation survey report with this application including changes in accreditation status.

12. Type of Legal Entity: Check the applicable box(es) below.

☐ Profit; check type of "For Profit" below:
Please check applicable boxes:
☐ Private Practitioner
☐ Faith-Based Provider
☐ Community Substance Abuse Coalition

☐ Non-Profit
☐ Foreign Limited Liability Partnership

13. Are you currently contracted with the Department of Children and Families?
☐ Yes ☐ No

14. Do you accept the following recipients?
☐ Medicaid ☐ Indigent Persons ☐ Pregnant Women

15. Is the agency incorporated with the State of Florida?
☐ Yes ☐ No

16. If so, is the corporation for profit? **Non-Profit Corporation requires submission of IRS Form 990.
☐ Yes ☐ No

If incorporated, submit the names of the owner, board members, officers and shareholders.
(*Must be Background screened per s. 397.4073, F.S., and Chapter 453, F.S.)

17. Name of Owner*

18a. Name of the Chief Executive Officer*	18b. Chief Executive Officer's Email Address

19. Name of the Chief Financial Officer*

20. Name of the Staff Training Coordinator

21. Name and professional license number of Medical Director (applies to addictions receiving facilities, detoxification, intensive inpatient treatment, residential treatment, day or night treatment, and medication-assisted treatment for opioid addiction). Submit proof of a valid medical license accompanied by, including but not limited to, the following documentation:

a. A copy of photo identification matching that of the physician named on the medical license; and

b. A letter from the physician attesting that he or she is (1) employed or contracted by the provider as a medical director, and specifying for which component he or she is acting (addictions receiving facility, detoxification, intensive inpatient treatment, residential treatment, or methadone medication-assisted treatment); and (2) knowledgeable of the limit to acting as medical director for no more than 10 facilities within a 200-mile radius.

Name of Medical Director*:_____ License Number:_____

An application without the applicable licensure fee as required under Section 397.407, Florida Statutes and Section 65D-30.0035, Florida Administrative Code, will be returned to the applicant. An application for renewal of a regular license must be submitted to the department at least 60 days before the license expires. A late fee of $100 per license component shall be assessed for the late filing of an application as required under Section 397.407(2) Florida Statutes.

Applications for renewal submitted less than 60 days, but at least 30 days before the license expires, will be processed and late fees will be applied. If the application for renewal is not received by the Department 30 days prior to the expiration of the regular license, the application will be denied and returned to the applicant, including any fees.

Please make check payable to the Florida Department of Children and Families.

I attest that the information provided is true, accurate and complete to the best of my knowledge.

Signature of the Chief Executive Officer (Original signature only)

Date (month, day, year)

II. PROGRAM COMPONENT INFORMATION – Location 1

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)	2. Telephone (Area Code & Number)

3. Street Address	4. Building Number, Room Number, Suite, etc.

5. City	6. State	7. Zip Code	8. Circuit/Region	9. County
	Florida			

10. Current License Number	11. Current License Expiration Date (MM/DD/YY)

12. Name of Program Director*	13. Name of Clinical Director*

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated

    Licensed Bed Capacity: _____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification

  Licensed Bed Capacity: _____
- ☐ Inpatient Methadone Detoxification

  Licensed Bed Capacity: _____
- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment

  Licensed Bed Capacity: _____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity: _____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity: _____

Licensed Bed Capacity: _____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

Location of Housing: _____

Total Bed Capacity: _____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Level 1 Prevention
- ☐ Level 2 Prevention

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Satellite Maintenance

  Maximum Capacity: _____

15. Hours during which the program is open:

Monday:	to	.....	☐ Closed
Tuesday:	to	.....	☐ Closed
Wednesday:	to	.....	☐ Closed
Thursday:	to	.....	☐ Closed
Friday:	to	.....	☐ Closed
Saturday:	to	.....	☐ Closed
Sunday:	to	.....	☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including the expiration date):

Expiration Date

Fire and Safety: ..... ☐ Yes ☐ No .....

Health Standards:

Facility Inspection: .... ☐ Yes ☐ No ☐ N/A ...

Food Services: ..... ☐ Yes ☐ No ☐ N/A ...

Zoning Compliance: ..... ☐ Yes ☐ No .....

Property Insurance: ..... ☐ Yes ☐ No .....

Professional Liability Insurance ..... ☐ Yes ☐ No .....

II. PROGRAM COMPONENT INFORMATION – Location 1 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ Drug Enforcement Agency (DEA) – Attached the DES registration for methadone medication-assisted maintenance treatment for opioid addiction.
- ☐ Substance Abuse and Mental Health Services Administration (SAMHSA) – Submit verification of certification relating to methadone medication-assisted treatment for opioid addiction.
- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

18. Have all staff and volunteers who have direct contact with clients under the age of 18 years or adults with developmental disabilities been fingerprinted and screened in accordance with section 397.4073(1)(a), Florida Statutes?

☐ Yes ☐ No ☐ Not Applicable

If applicable, submit the treatment resource attestation with this application.

19. What is the maximum number of clients that can be served in this component on a given day?

20. What is the maximum number of clients that can be served in this component on a given day?

21. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (Non-Hispanic) ☐ None

☐ Other (please describe):

22. List any special population group targeted for services (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal justice clients, etc.)

- ☐ Children
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post Partum Women
- ☐ Pregnant and Post Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

23. List the complete names of agencies, practitioners or recovery residences with which you have written referral agreements, contracts, or subcontracts, and check the type of business relationship:

a.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
e.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):

24. List the sources of revenue you receive by name and check the type of funds, e.g., state funds, federal funds, fees, etc:

a.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
b.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
c.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
d.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
e.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):

II. PROGRAM COMPONENT INFORMATION – Location 2

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)	2. Telephone (Area Code & Number)

3. Street Address	4. Building Number, Room Number, Suite, etc.

5. City	6. State	7. Zip Code	8. Circuit/Region	9. County
	Florida			

10. Current License Number	11. Current License Expiration Date (MM/DD/YY)

12. Name of Program Director*	13. Name of Clinical Director*

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated

  Licensed Bed Capacity: _____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification

  Licensed Bed Capacity: _____
- ☐ Inpatient Methadone Detoxification

  Licensed Bed Capacity: _____
- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment

  Licensed Bed Capacity: _____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity: _____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity: _____

Licensed Bed Capacity: _____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

Location of Housing: _____

Total Bed Capacity: _____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Level 1 Prevention
- ☐ Level 2 Prevention

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Satellite Maintenance

Maximum Capacity: _____

15. Hours during which the program is open:

Monday:	to	.....	☐ Closed
Tuesday:	to	.....	☐ Closed
Wednesday:	to	.....	☐ Closed
Thursday:	to	.....	☐ Closed
Friday:	to	.....	☐ Closed
Saturday:	to	.....	☐ Closed
Sunday:	to	.....	☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including the expiration date):

Expiration Date

Fire and Safety: ..... ☐ Yes ☐ No .....

Health Standards:

Facility Inspection: .... ☐ Yes ☐ No ☐ N/A ...

Food Services: ..... ☐ Yes ☐ No ☐ N/A ...

Zoning Compliance: ..... ☐ Yes ☐ No .....

Property Insurance: ..... ☐ Yes ☐ No .....

Professional Liability Insurance ..... ☐ Yes ☐ No .....

II. PROGRAM COMPONENT INFORMATION – Location 2 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ Drug Enforcement Agency (DEA) – Attached the DES registration for methadone medication-assisted maintenance treatment for opioid addiction.
- ☐ Substance Abuse and Mental Health Services Administration (SAMHSA) – Submit verification of certification relating to methadone medication-assisted treatment for opioid addiction.
- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

18. Have all staff and volunteers who have direct contact with clients under the age of 18 years or adults with developmental disabilities been fingerprinted and screened in accordance with section 397.4073(1)(a), Florida Statutes?

☐ Yes ☐ No ☐ Not Applicable

If applicable, submit the treatment resource attestation with this application.

19. What is the maximum number of clients that can be served in this component on a given day?

20. What is the maximum number of clients that can be served in this component on a given day?

21. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (Non-Hispanic) ☐ None

☐ Other (please describe):

22. List any special population group targeted for services (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal justice clients, etc.)

- ☐ Children
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post Partum Women
- ☐ Pregnant and Post Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

23. List the complete names of agencies, practitioners or recovery residences with which you have written referral agreements, contracts, or subcontracts, and check the type of business relationship:

a.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
e.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):

24. List the sources of revenue you receive by name and check the type of funds, e.g., state funds, federal funds, fees, etc:

a.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
b.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
c.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
d.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
e.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):

II. PROGRAM COMPONENT INFORMATION – Location 3

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)	2. Telephone (Area Code & Number)
3. Street Address	4. Building Number, Room Number, Suite, etc.

5. City	6. State	7. Zip Code	8. Circuit/Region	9. County

10. Current License Number	11. Current License Expiration Date (MM/DD/YY)
12. Name of Program Director*	13. Name of Clinical Director*

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated

Licensed Bed Capacity: _____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification
  Licensed Bed Capacity: _____
- ☐ Inpatient Methadone Detoxification
  Licensed Bed Capacity: _____
- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment
  Licensed Bed Capacity: _____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity: _____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity: _____

Licensed Bed Capacity: _____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

Location of Housing: _____

Total Bed Capacity: _____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Level 1 Prevention
- ☐ Level 2 Prevention

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Satellite Maintenance

Maximum Capacity: _____

15. Hours during which the program is open:

Monday:	to	.....	☐ Closed
Tuesday:	to	.....	☐ Closed
Wednesday:	to	.....	☐ Closed
Thursday:	to	.....	☐ Closed
Friday:	to	.....	☐ Closed
Saturday:	to	.....	☐ Closed
Sunday:	to	.....	☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including the expiration date):

Expiration Date

Fire and Safety: ..... ☐ Yes ☐ No .....

Health Standards:

Facility Inspection: .... ☐ Yes ☐ No ☐ N/A ...

Food Services: ..... ☐ Yes ☐ No ☐ N/A ...

Zoning Compliance: ..... ☐ Yes ☐ No .....

Property Insurance: ..... ☐ Yes ☐ No .....

Professional Liability Insurance ..... ☐ Yes ☐ No .....

II. PROGRAM COMPONENT INFORMATION – Location 3 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ Drug Enforcement Agency (DEA) – Attached the DES registration for methadone medication-assisted maintenance treatment for opioid addiction.
- ☐ Substance Abuse and Mental Health Services Administration (SAMHSA) – Submit verification of certification relating to methadone medication-assisted treatment for opioid addiction.
- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

18. Have all staff and volunteers who have direct contact with clients under the age of 18 years or adults with developmental disabilities been fingerprinted and screened in accordance with section 397.4073(1)(a), Florida Statutes?

☐ Yes ☐ No ☐ Not Applicable

If applicable, submit the treatment resource attestation with this application.

19. What is the maximum number of clients that can be served in this component on a given day?

20. What is the maximum number of clients that can be served in this component on a given day?

21. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (Non-Hispanic) ☐ None

☐ Other (please describe):

22. List any special population group targeted for services (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal justice clients, etc.)

- ☐ Children
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post Partum Women
- ☐ Pregnant and Post Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

23. List the complete names of agencies, practitioners or recovery residences with which you have written referral agreements, contracts, or subcontracts, and check the type of business relationship:

a.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
e.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):

24. List the sources of revenue you receive by name and check the type of funds, e.g., state funds, federal funds, fees, etc:

a.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
b.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
c.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
d.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):
e.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other (specify):