Application for Designation as a Baker Act Receiving Facility

Submission Date (Month/Day/Year)

☐ New Application
☐ Renewal

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
	Florida		

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

10. Please list the physical address for each facility:

10a. City	10a. State Florida	10a. Zip Code	10a. County
10b. City	10b. State Florida	10b. Zip Code	10b. County
10c. City	10c. State Florida	10c. Zip Code	10c. County
10d. City	10d. State Florida	10d. Zip Code	10d. County

11a. Provider Point of Contact Name and Email Address:

12. Designation Facility Type:

☐ Hospital — Licensed Bed Capacity: _____
☐ Crisis Stabilization Unit — Licensed Bed Capacity: _____
☐ Children's Crisis Stabilization Unit — Licensed Bed Capacity: _____
☐ Short-term Residential Treatment — Licensed Bed Capacity: _____

13. Description of proposed psychiatric services including any distinct programs to be provided to each of the following age groups, including projected numbers of persons to be served.

	Psychiatric Services	**Distinct Programs**	**Projected Number Served**
Minors below 10 years of age			
Minors between the ages of 10 to 17 years			
Adults			
Persons 60 or more years of age			
Other specialty groups (i.e., homeless or gender specific)			

14. Please submit with your application the following:

a. A copy of facility's license issued by Agency for Health Care Administration (AHCA). Which must be submitted within 30 calendars days of receipt to maintain designation. ☐ Attached
b. Accreditation status and submission of the latest survey report of any applicable accrediting bodies.
c. Policy & Procedure Manual: ☐ Attached
d. Key facility protocols to assure all involved practitioners and staff are knowledgeable of, and implement, an individual's legal rights, key psychiatric care, records standards, complaint reporting, investigation, and reviews to maintain a consistently high level of compliance with applicable Baker Act laws, ethical principles, and rights protections. ☐ Attached
e. Description of how the facility's discharge planning policies provide for continuity of psychotropic medication availability until post-discharge follow-up services are scheduled. ☐ Attached

Attestation

I, _____, attest as follows:

(1) Pursuant to section 837.06 Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Department in the performance of its official duty.

(2) I acknowledge that false representation of a material fact in the application or omission of any material fact from the application may be used by the Department for suspension or withdrawal of designation.

(3) Pursuant to section 408.809, 435.05, 394.4572, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury to meeting the requirements for qualifying got employment pursuant to Chapter 408, Part II and Chapter 435 Florida Statute, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer

(4) Pursuant to section 435.05 Florida Statutes, the applicant has conducted a level 2 background screening on every employee required to be secerned under Chapter 408, Part II or Chapter 435 Florida statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screenings standards or obtained an exemption from disqualification from employment.

Please complete question five for renewal applications only:

(5) There have been no changes made to the following documents (renewals only-please check all that apply):

☐ Policy and Procedure Manual

☐ Description of how the facility's discharge planning policies provide for continuity of psychotropic medication availability until post-discharge follow-up services are scheduled

Note for question 5: ***If changes have occurred, the Provider must submit the current documentation to the Department through PLADS to be processed with the renewal application. All other required documentation for renewal must be submitted on an annual basis. For new applicants, all required documents must be submitted to process your application.***

_____ _____

Signature of the Chief Executive Officer (Original signature only) Date (month, day, year)