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Application For Licensing to Provide SUBSTANCE ABUSE TREATMENT SERVICES

Submission Date (Month/Day/Year)
Click or tap here to enter text.

☐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) Click or tap here to enter text.	2. Federal ID # Click or tap here to enter text.	3. National Provider ID (NPI) Click or tap here to enter text.

4. Name of the Service Providers 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 & Number)

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

10e. Provider Point of Contact Email Address

11. Is the applicant accredited by a certifying organization approved by the department? If so, please include the accrediting organizations information below:
Name of the 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. Is the Agency incorporated with the State of Florida? ☐Yes ☐No	14. 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 Section 397.4073, F.S., and Chapter 453, F.S.)

15. Name of Owner*

16a. Name of the Chief Executive Officer*	16b. Chief Executive Officer's Email Address

17. Name of the Chief Financial Officer*

18. Name of the Staff Training Coordinator

19. 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: _____

EXEMPTIONS: Pursuant to Chapter 397.4014, F.S., Inmate Substance Abuse Programs are exempt from providing specific documentation in the application process. "Inmate Substance Abuse Services" means any service component as defined in S. 397.311 provided directly by the Department of Corrections and licensed and regulated by the Department of Children and Families pursuant to Chapter 397.752 – 397.754, F.S. or provided through contractual arrangements with a service provider licensed pursuant to Chapter 397, Part VIII, or any self-help program or volunteer support group operating for inmates.

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 calendar 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.

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)

Renewal Attestation

I, _____, attest as follows:

(1) Pursuant to section 408.809, 435.05, 397.4073, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury to meeting the requirements for qualifying 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.

(2) Pursuant to section 435.05 Florida Statutes, the applicant has conducted a level 2 background screening on every employee required to be screened 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.

(3) There have been no changes made to the following (please check all that apply):

☐Policy and Procedure Manual

☐Organizational Chart

☐Verification of Qualified Professional(s) (Must be resubmitted every 3 years)

☐Service Fee/Service Component

Note: If changes have occurred, the Provider must submit the current documentation to the Department via PLADS in order 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 in order to process your application.

_____ _____

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

II. PROGRAM COMPONENT INFORMATION – SITE 1
(If the site has multiple buildings, please enter an address for each building.)

1. Name of Site (e.g., Courtney's House of Hope)		2. Telephone (Area Code Number)		
3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State FLORIDA	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

☐ Addiction Receiving Facility

☐ Juvenile Addictions Receiving Facility

☐ Integrated

Licensed Bed Capacity:

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Inpatient Detoxification

Licensed Bed Capacity: _____

☐ Inpatient Methadone Detoxification

Licensed Bed Capacity: _____

☐ Outpatient Detoxification

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

☐ Day or Night Treatment Programs with Community Housing

Location of Housing:

Total Bed Capacity: _____

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Day or Night Treatment

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

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

☐ Aftercare

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Case Management

☐ General Intervention

☐ Employee Assistance Program

☐ Treatment Alternatives for Safer Communities (TASC)

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

☐ Outpatient Methadone Detoxification

☐ Mobile Units (*If so please complete section 18*)

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Inpatient Treatment

Licensed Bed Capacity:

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Outpatient Treatment

☐ Overlay Services

☐ Mobile Unit (*If so please complete section 18*)

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Outpatient Treatment

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

14k. Prevention Programs:

☐ Universal Direct

☐ Selective

☐ Indicated

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Medication and Methadone Maintenance Treatment

_____

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: _____

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

☐ Overlay Services

☐ Mobile Unit *(If so please complete section 18*)

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

☐ Medication Unit

☐ Mobile Unit (*If so please complete section 18*)

Maximum Capacity: _____

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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 applicable expiration date):

Expiration Date: _____

Fire and Safety:	☐Yes	
Health Standards:	☐Yes	☐N/A
Facility Inspection:	☐Yes	☐N/A
Food Services	☐Yes	
Zoning Compliance:	☐Yes	
Property Insurance:	☐Yes	
Professional Liability Insurance:		
Recovery Residence Referral Log:	☐Yes	☐N/A
Attestation of Good Moral Character:	☐Yes	
Policy & Procedure Manual:	☐Yes	☐N/A
Current Organizational Chart:	☐Yes	
Level 2 Background Screening:	☐Yes	

	Verification of Qualifies Professional(s): ☐Yes Service Fee Schedule ☐Yes Policies regarding an Individual's financial responsibility: ☐Yes Provide proof of the ability and provision of meals for the following: Addiction receiving facilities: ☐Yes Day and Night Treatment, If applicable: ☐Yes Residential Treatment: ☐Yes Day and Night Treatment, If applicable: ☐Yes Day or Night Treatment with Community Housing: ☐Yes Inpatient Detoxification: ☐Yes Intensive Inpatient Treatment: ☐Yes **Note:** Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.

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.**

☐Verification of the services of a consultant pharmacist

☐Not Applicable

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

18. Methadone Mobile Unit. If providing mobile methadone medication assisted treatment unit services, **submit copies of required documents with this application.**

☐A description of the vehicle: Size, capacity, configuration (identifying medication storage areas, record keeping areas, public service/treatment areas) and security features to safeguard the vehicle, medication, and safety of staff and individuals served.

☐Description of the targeted population, geographical service area, and hours of operation

☐Attestation that the mobile medication unit complies with Title 21 of the Code of Federal Regulations, Parts 1300, 1301, and 1304, 42 Code of Federal Regulations, Part 8, and Chapter 65D-30, Florida Administrative Code.

☐Copy of all existing applicable state and federal certifications, licenses and approvals.

☐Security plans for the mobile medication-assisted treatment and medication, including procedure to transport, secure, and log any medication back inside the licensed provider site at the end of the business day.

☐ Written plan to participate in the state's central registry.

☐Contingency plans for mobile unit closure including but not limited to: adverse weather events, human-induced disasters, unit breakdown, and vehicle maintenance plan.

☐Written plan for disaster preparedness and include plans to secure, operate, and staff the mobile unit.

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

19. 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 Statues? ☐Yes ☐No ☐Not Applicable	20. What is the maximum number of clients that can be served in this component on a given day? Click or tap here to enter text.

21. Target Population:

☐White (Non-Hispanic) ☐American Indian ☐Hispanic ☐Black(Non-Hispanic)

☐Other (please describe) Click or tap here to enter text.

22. List any special population group targeted for services

☐Children	☐HIV/AIDS
☐Women	☐Hearing Impaired
☐Adolescents	☐Visually Impaired
☐Homeless	☐Older Adults
☐Criminal Justice-Involved Adults	☐Co-occurring
☐Juvenile Justice-Involved Youth	☐Intravenous Drug Users
☐Pregnant and Post-Partum Women	☐Other (Please describe other group): Click or tap here to enter text.
☐Pregnant and Post-Partum Adolescents	

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

a) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

b) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

c) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

d) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

e) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

II. PROGRAM COMPONENT INFORMATION –SITE 2
(If the site has multiple buildings, please enter an address for each building.)

1. Name of Site (e.g., Courtney's House of Peace)		2. Telephone (Area Code Number)		
3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State FLORIDA	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

☐ Addiction Receiving Facility

☐ Juvenile Addictions Receiving Facility

☐ Integrated

Licensed Bed Capacity:

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Inpatient Detoxification

Licensed Bed Capacity: _____

☐ Inpatient Methadone Detoxification

Licensed Bed Capacity: _____

☐ Outpatient Detoxification

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

☐ Day or Night Treatment Programs with Community Housing

Location of Housing:

Total Bed Capacity: _____

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Day or Night Treatment

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

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

☐ Aftercare

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Case Management

☐ General Intervention

☐ Employee Assistance Program

☐ Treatment Alternatives for Safer Communities (TASC)

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

☐ Outpatient Methadone Detoxification

☐ Mobile Units (*If so please complete section 18*)

Address(es): _____
Telehealth offered: ☐ Yes ☒No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Inpatient Treatment

Licensed Bed Capacity:

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Outpatient Treatment

☐ Overlay Services

☐ Mobile Unit (*If so please complete section 18*)

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

14k. Prevention Programs:

☐ Universal Direct

☐ Selective

☐ Indicated

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Medication and Methadone

_____

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: _____

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Outpatient Treatment

☐ Overlay Services

☐ Mobile Unit *(If so please complete section 18)*

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

Maintenance Treatment

☐ Medication Unit

☐ Mobile Unit (*If so please complete section 18*)

Maximum Capacity: _____

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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 applicable expiration date):

Expiration Date: _____

Fire and Safety:	☐Yes	
Health Standards:	☐Yes	☐N/A
Facility Inspection:	☐Yes	☐N/A
Food Services	☐Yes	
Zoning Compliance:	☐Yes	
Property Insurance:	☐Yes	
Professional Liability Insurance:		
Recovery Residence Referral Log:	☐Yes	☐N/A
Attestation of Good Moral Character:	☐Yes	

	Policy & Procedure Manual: ☐Yes ☐N/A Current Organizational Chart: ☐Yes Level 2 Background Screening: ☐Yes Verification of Qualifies Professional(s): ☐Yes Service Fee Schedule ☐Yes
i	Policies regarding an Individual's financial responsibility: ☐Yes Provide proof of the ability and provision of meals for the following: Addiction receiving facilities: ☐Yes Day and Night Treatment, If applicable: ☐Yes Residential Treatment: ☐Yes Day and Night Treatment, If applicable: ☐Yes Day or Night Treatment with Community Housing: ☐Yes Inpatient Detoxification: ☐Yes Intensive Inpatient Treatment: ☐Yes **Note:** Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.

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.**

☐Verification of the services of a consultant pharmacist

☐Not Applicable

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

18. Methadone Mobile Unit. If providing mobile medication assisted treatment unit services, **submit copies of required documents with this application.**

☐ ☐A description of the vehicle: Size, capacity, configuration (identifying medication storage areas, record keeping areas, public service/treatment areas) and security features to safeguard the vehicle, medication, and safety of staff and individuals served.

☐Description of the targeted population, geographical service area, and hours of operation.

☐Attestation that the mobile medication unit complies with Title 21 of the Code of Federal Regulations, Parts 1300, 1301, and 1304, 42 Code of Federal Regulations, Part 8, and Chapter 65D-30, Florida Administrative Code.

☐Copy of all existing applicable state and federal certifications, licenses and approvals.

☐Security plans for the mobile medication-assisted treatment and medication, including procedure to transport, secure, and log any medication back inside the licensed provider site at the end of the business day.

☐Contingency plans for mobile unit closure including but not limited to: adverse weather events, human-induced disasters, unit breakdown, and vehicle maintenance plan.

☐Written plan for disaster preparedness and include plans to secure, operate, and staff the mobile unit.

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

19. 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 Statues? ☐Yes ☐No ☐Not Applicable	20. What is the maximum number of clients that can be served in this component on a given day? Click or tap here to enter text.

21. Target Population:

☐White (Non-Hispanic) ☐American Indian ☐Hispanic ☐Black (Non-Hispanic)

☐Other (please describe) Click or tap here to enter text.

22. List any special population group targeted for services

☐Children	☐HIV/AIDS
☐Women	☐Hearing Impaired
☐Adolescents	☐Visually Impaired
☐Homeless	☐Older Adults
☐Criminal Justice-Involved Adults	☐Co-occurring
☐Juvenile Justice-Involved Youth	☐Intravenous Drug Users
☐Pregnant and Post-Partum Women	☐Other (Please describe other group):
☐Pregnant and Post-Partum Adolescents	Click or tap here to enter text.

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

f) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

g) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

h) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

i) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

j) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

II. PROGRAM COMPONENT INFORMATION – SITE 3
(If the site has multiple buildings, please enter an address for each building.)

1. Name of Site (e.g., Courtney's House of Love)		2. Telephone (Area Code Number)		
3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State FLORIDA	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

☐ Addiction Receiving Facility

☐ Juvenile Addictions Receiving Facility

☐ Integrated

Licensed Bed Capacity:

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Inpatient Detoxification

Licensed Bed Capacity: _____

☐ Inpatient Methadone Detoxification

Licensed Bed Capacity: _____

☐ Outpatient Detoxification

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

☐ Day or Night Treatment Programs with Community Housing

Location of Housing:

Total Bed Capacity: _____

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Day or Night Treatment

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

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

☐ Aftercare

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:

☐Department of Corrections

☐Department of Juvenile Justice

☐Agency for Health Care Administration

☐Department of Children and Families (includes managing entities)

☐Agency for Persons with Disabilities

☐Medicaid

☐Medicare

Private Funding Sources Accepted:

☐Private Pay

☐Blue Cross Blue Shield

☐Sunshine Health

☐Aetna

☐Humana

☐United Healthcare

☐Other: (Please Specify)

_____

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

☐ Case Management

☐ General Intervention

☐ Employee Assistance Program

☐ Treatment Alternatives for Safer Communities (TASC)

☐ Overlay Services

Address(es): _____

Telehealth offered: ☐ Yes ☐No

☐ Outpatient Methadone Detoxification

☐ Mobile Units (*If so please complete section 18*)

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Inpatient Treatment

Licensed Bed Capacity:

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

☐ Intensive Outpatient Treatment

☐ Overlay Services

☐ Mobile Unit (*If so please complete section 18*)

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

14k. Prevention Programs:

☐ Universal Direct

☐ Selective

☐ Indicated

Address(es): _____
Telehealth offered: ☐ Yes ☐No

Public Funding Sources Accepted:
☐Department of Corrections
☐Department of Juvenile Justice
☐Agency for Health Care Administration
☐Department of Children and Families (includes managing entities)
☐Agency for Persons with Disabilities
☐Medicaid
☐Medicare

Private Funding Sources Accepted:
☐Private Pay
☐Blue Cross Blue Shield
☐Sunshine Health
☐Aetna
☐Humana
☐United Healthcare
☐Other: (Please Specify)

_____

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

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: _____ Address(es): _____ Telehealth offered: ☐ Yes ☐No Public Funding Sources Accepted: ☐Department of Corrections ☐Department of Juvenile Justice ☐Agency for Health Care Administration ☐Department of Children and Families (includes managing entities) ☐Agency for Persons with Disabilities ☐Medicaid ☐Medicare Private Funding Sources Accepted: ☐Private Pay ☐Blue Cross Blue Shield ☐Sunshine Health ☐Aetna ☐Humana ☐United Healthcare ☐Other: (Please Specify) _____	14h. ***Outpatient Programs:*** ☐ Outpatient Treatment ☐ Overlay Services ☐ Mobile Unit *(If so please complete section 18*) Address(es): _____ Telehealth offered: ☐ Yes ☐No Public Funding Sources Accepted: ☐Department of Corrections ☐Department of Juvenile Justice ☐Agency for Health Care Administration ☐Department of Children and Families (includes managing entities) ☐Agency for Persons with Disabilities ☐Medicaid ☐Medicare Private Funding Sources Accepted: ☐Private Pay ☐Blue Cross Blue Shield ☐Sunshine Health ☐Aetna ☐Humana ☐United Healthcare ☐Other: (Please Specify) _____	☐ Medication and Methadone Maintenance Treatment ☐ Medication Unit ☐ Mobile Unit (*If so please complete section 18*) Maximum Capacity: _____ Address(es): _____ Telehealth offered: ☐ Yes ☐No Public Funding Sources Accepted: ☐Department of Corrections ☐Department of Juvenile Justice ☐Agency for Health Care Administration ☐Department of Children and Families (includes managing entities) ☐Agency for Persons with Disabilities ☐Medicaid ☐Medicare Private Funding Sources Accepted: ☐Private Pay ☐Blue Cross Blue Shield ☐Sunshine Health ☐Aetna ☐Humana ☐United Healthcare ☐Other: (Please Specify) _____

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 applicable expiration date):

Expiration Date: _____

Fire and Safety:	☐Yes	
Health Standards:	☐Yes	☐N/A
Facility Inspection:	☐Yes	☐N/A
Food Services	☐Yes	
Zoning Compliance:	☐Yes	
Property Insurance:	☐Yes	
Professional Liability Insurance:		
Recovery Residence Referral Log:	☐Yes	☐N/A
Attestation of Good Moral Character:	☐Yes	
Policy & Procedure Manual:	☐Yes	☐N/A
Current Organizational Chart:	☐Yes	
Level 2 Background Screening:	☐Yes	
Verification of Qualifies Professional(s):	☐Yes	
Service Fee Schedule	☐Yes	

Policies regarding an Individual's financial responsibility:

☐Yes

Provide proof of the ability and provision of meals for the following:

Addiction receiving facilities: ☐Yes

Day and Night Treatment, If applicable: ☐Yes

Residential Treatment: ☐Yes

Day and Night Treatment, If applicable: ☐Yes

Day or Night Treatment with Community Housing: ☐Yes

Inpatient Detoxification: ☐Yes

Intensive Inpatient Treatment: ☐Yes

Note: Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.

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☐Verification of the services of a consultant pharmacist

☐Not Applicable

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

18. Methadone Mobile Unit. If providing mobile medication assisted treatment unit services, **submit copies of required documents with this application.**

☐A description of the vehicle: Size, capacity, configuration (identifying medication storage areas, record keeping areas, public service/treatment areas) and security features to safeguard the vehicle, medication, and safety of staff and individuals served.

☐Description of the targeted population, geographical service area, and hours of operation

☐Attestation that the mobile medication unit complies with Title 21 of the Code of Federal Regulations, Parts 1300, 1301, and 1304, 42 Code of Federal Regulations, Part 8, and Chapter 65D-30, Florida Administrative Code.

☐Copy of all existing applicable state and federal certifications, licenses and approvals.

☐Security plans for the mobile medication-assisted treatment and medication, including procedure to transport, secure, and log any medication back inside the licensed provider site at the end of the business day.

☐Written plans to participate in the central registry.

☐Contingency plans for mobile unit closure including but not limited to: adverse weather events, human-induced disasters, unit breakdown, and vehicle maintenance plan.

☐Written plan for disaster preparedness and include plans to secure, operate, and staff the mobile unit.

Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.

19. 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 Statues? ☐Yes ☐No ☐Not Applicable	20. What is the maximum number of clients that can be served in this component on a given day? Click or tap here to enter text.

21. Target Population:

☐White (Non-Hispanic) ☐American Indian ☐Hispanic ☐Black (Non-Hispanic)

☐Other (please describe) Click or tap here to enter text.

22. List any special population group targeted for services

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☐Women	☐Hearing Impaired
☐Adolescents	☐Visually Impaired
☐Homeless	☐Older Adults
☐Criminal Justice-Involved Adults	☐Co-occurring
☐Juvenile Justice-Involved Youth	☐Intravenous Drug Users
☐Pregnant and Post-Partum Women	☐Other (Please describe other group): Click or tap here to enter text.
☐Pregnant and Post-Partum Adolescents	

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

k) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

l) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

m) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

n) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.

o) ☐Agreement ☐Contract ☐Subcontract ☐Other (specify):Click or tap here to enter text.