	Application for Licensure to Provide **SUBSTANCE ABUSE SERVICES**	Submission Date (Month, Day, Year) ☐ New Application ☐ Renewal ☐ Relocation (Anticipated Relocation Date)

I. SERVICE PROVIDER INFORMATION
FOR PROVIDERS WITH MULITIPLE SITES, ENTER CORPORATE HEADQUARTER INFORMATION

1. Service Provider Name **(If multiple locations enter CORPORATE HEADQUARTERS name)**			2. Federal ID #
3. Name of the Service Provider's Owner		4. Point of Contact Email Address	
5. Mailing Address			
5a. City	5b. State **Florida**	5c. Zip Code	5d. County
6. Street Address (if different than mailing address)			
6a. City	6b. State **Florida**	6c. Zip Code	6d. County
7. Circuit/Region	8. Telephone (Area Code & Number)	9. Fax Telephone (Area Code & Number)	

10. Please check the applicable box(es) below. ☐ Publicly Funded Provider ☐ Privately Funded Provider ☐ Private Practitioner ☐ Faith-Based Provider ☐ Community Substance Abuse Coalition	11. Is the applicant accredited by a certifying organization approved by the department? If so, please check the applicable box. ☐ Commission on Accreditation of Rehabilitation Facilities (CARF) ☐ Three-Year ■ One-Year ☐ The Joint Commission ☐ Council on Accreditation (COA) Accreditation Expiration Date **Please submit the most recent accreditation survey report with this application including changes in accreditation status.**
12. Is the agency incorporated with the State of Florida? ☐ Yes ☐ No	13. If so, is the corporation for profit? ☐ Yes ☐ No

If incorporated, please submit the names of the owner, board members, officers, and shareholders.

14. Name of Owner	
15a. Name of Chief Executive Officer	15b. Chief Executive Officer Email Address
16. Name of Chief Financial Officer	
17. Name of Staff Training Coordinator	
18. 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 and methadone maintenance treatment services.)	

An application without the applicable licensure fee as required under section 397.407, Florida Statutes and 65D-30.003(5), Florida Administrative Code, will be returned to the applicant. An application for renewal of a regular license must be submitted to the department no later than 60 days before the license expires. A late fee of $100 per license 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 & Families.

II. PROGRAM COMPONENT INFORMATION

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)

2. Street Address

3. Building Number, Room Number, Suite, etc.

4. City	5. State **Florida**	6. Zip Code
7. Circuit/Region	8. County	9. Telephone (Area Code & Number)

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

Type of Service Component **(please check only one service per component application)**:

14a. Addictions Receiving Facility:

☐ Addictions Receiving Facility

Bed Capacity

14b. Detoxification Programs:

☐ Residential Detoxification

Bed Capacity

☐ Outpatient Detoxification

☐ Residential Methadone Detoxification

Bed Capacity

☐ Outpatient Methadone Detoxification

14c. Intensive Inpatient Treatment Programs:

☐ Intensive Inpatient Treatment

Bed Capacity

14d. Residential Programs:

☐ Level 1 Bed Capacity

☐ Level 2 Bed Capacity

☐ Level 3 Bed Capacity

☐ Level 4 Bed Capacity

☐ Level 5 Bed Capacity

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

☐ Day or Night Treatment Programs with Community Housing

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

14k. Prevention Programs:

☐ Level 1 Prevention

☐ Level 2 Prevention

14l. Medication & Methadone Maintenance Treatment Programs:

☐ Medication & Methadone Maintenance Treatment

☐ Satellite Maintenance

15. DCF Contracted Bed Capacity (Residential, Inpatient, Residential Detox, Addictions Receiving Facilities)	16. Licensed Bed Capacity (Residential, Inpatient, Residential Detox, Addictions Receiving Facilities)

17. 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

18. Please submit evidence of compliance for applicable areas below (including the expiration date):

Fire and Safety	☐ Yes	☐ No		Date:
Health Standards				
Facility Inspection	☐ Yes	☐ No	☐ N/A	Date:
Food Services	☐ Yes	☐ No	☐ N/A	Date:
Zoning Compliance	☐ Yes	☐ No		Date:
Property Insurance	☐ Yes	☐ No		Date:
Professional Liability Insurance	☐ Yes	☐ No		Date:

Please submit all approval documents with this application

19. Medication and Methadone Maintenance Treatment components, (i.e., programs which use methadone or other medications for treating opioid addiction). Approved by:	20. Have all staff and volunteers who have direct contact with clients under the age of 18 years been finger printed and screened in accordance with section 397.451(1)(a), Florida Statutes?
☐ Drug Enforcement Administration (DEA) ☐ Substance Abuse and Mental Health Services Administration (SAMHSA) ☐ State Methadone Authority ☐ Board of Pharmacy ☐ Not Applicable **Please submit copies of approval documents with this application.**	☐ Yes ☐ No ☐ Not Applicable **Please submit the treatment resource affidavit with this application**

21. Please check the client population, which have been targeted for services.

- ☐ White (Non-Hispanic)
- ☐ Black (Non-Hispanic)
- ☐ Hispanic
- ☐ American Indian
- ☐ None
- ☐ Other (please describe)

22. Please 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. Services provided: Please check all major services provided on a regular basis either directly by the program or upon referral.

Program Services	**Provided Directly by Program**	**Provided by Written Agreement or Referral**	**Not Applicable**
Individual Counseling	☐	☐	☐
Group Counseling	☐	☐	☐
Family Counseling	☐	☐	☐
Job Consulting and Placement	☐	☐	☐
Job Training	☐	☐	☐
Education Services	☐	☐	☐
Aftercare (Non-Structured)	☐	☐	☐
General Health Care	☐	☐	☐
Legal Services	☐	☐	☐
Social Services (Welfare, Housing, etc.)	☐	☐	☐
Cultural/Recreational Programs	☐	☐	☐
Other (Please Describe)	☐	☐	☐

24. Do you charge client fees? If so, please attach a copy of the fee schedule and fee policy. ☐ Yes ☐ No	25. What is the maximum number of clients that can be served in this component on a given day?	26. What is your projected operating budget for the component *listed on this application* for the current year?

27. Please list the complete names of agencies or practitioners you have written referral agreements, contracts, or subcontracts with 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)
f.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other(Specify)
g.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other(Specify)
h.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other(Specify)
i.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other(Specify)
j.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other(Specify)

28. Please 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)
f.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other(Specify)
g.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other(Specify)
h.	☐ State	☐ Federal	☐ Fees	☐ Private	☐ Other(Specify)

29. Please further describe your program listed in item #1 on page 2. **For counseling programs, this information should include the number of counseling sessions provided weekly, the duration of each counseling session, and the average length of stay in the program.**

30. Signature of the Chief Executive Officer (Original signature only)	31. Date (Month, Day, Year)