

STATE OF MAINE
Department of Health and Human Services
Division of Licensing and Regulatory Services

**APPLICATION FOR LICENSURE
ALCOHOL & DRUG TREATMENT PROGRAM**

Date: _____

APPLICATION IS FOR: New License: _____ Renewal of License: _____

 Add A Service: _____ Add A Site: _____ Add Affiliate: _____

NAME OF FACILITY/AGENCY: _____

ADDRESS:

(City, State, Zip)

MAILING ADDRESS: (if different)

(City, State, Zip)

COUNTY: _____

NAME OF CONTACT PERSON: _____

PHONE #: _____ FAX #: _____ EMAIL: _____

NAME/TITLE OF ADMINISTRATOR/OPERATOR: _____

PHONE #: _____ FAX #: _____ EMAIL: _____

NAME OF EXECUTIVE DIRECTOR: _____

STATE TAX ID # OR EMPLOYER ID #: _____

ACCREDITATION: Are you accredited? Yes (____) No (____) If yes, please indicate which accrediting agency: _____. How many years have you held that accreditation? _____

CORPORATION NAME/ADDRESS (if different): _____

TYPE OF FACILITY/AGENCY:

Individual Proprietorship: _____
Non-Profit Corporation: _____
Tribal Government: _____
Church: _____

Partnership: _____
For-Profit Corporation: _____
Parent Co-op: _____
Other (describe): _____

STAFF ROSTER

FULL NAME _____ TITLE _____ DATE OF BIRTH _____
EDUCATION/DEGREE _____ LICENSE/CERTIFICATION _____
SUPERVISOR _____ TITLE _____

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EDUCATION/DEGREE _____ LICENSE/CERTIFICATION _____
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SUPERVISOR _____ TITLE _____

(Use additional paper if necessary.)

SERVICES BEING APPLIED FOR

(Include Module Type, Specific Service, and each location from which service will be delivered, number of clients, age range, and gender. (Attach additional sheets if necessary).

MODULE: _____ SERVICE: _____ # OF CLIENTS: _____
AGE RANGE: _____ GENDER: _____
LOCATION ADDRESS: _____

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FIRE INSPECTION REQUEST & ADDRESS CHANGE FORM

Type of License: ALCOHOL AND SUBSTANCE ABUSE

Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

FORM MUST BE COMPLETED BY:

1. New Applicants: Complete one form for each site from which you plan to deliver services and return with your application. (NEED ONE FORM FOR EACH SITE)
2. All Applicants: Complete and submit form when you are adding a site, changing your address, or closing a site. (KEEP A COPY OF THE FORM FOR YOUR RECORDS)

MAIN SITE:

Agency Name: _____ Date: _____
Operator/Exec. Director: _____ Phone: _____
Address: _____ Contact Person (if different): _____

(City, State, Zip) Phone: _____

DESCRIPTION OF SERVICES: _____

AGE RANGE OF CLIENTS SERVED: _____ MAXIMUM CAPACITY: _____

RESIDENTIAL: _____ NON-RESIDENTIAL: _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____

COMPLETE ONLY IF CHANGE:

Services cannot be provided at any location until Licensing and the Fire Marshal's Office have approved the site.

New Program/Agency In Process of Licensure _____

Closing Existing Site _____ *Address:* _____

Moving Office Site Within Same Building _____

Adding New Site _____ *Address:* _____

NEW SITE: *Date of Expected Move:* _____
Contact Person: _____ *Phone:* _____

WATER SOURCE: *Municipal* _____ *Well* _____ *Other* _____

DIRECTIONS TO FACILITY: (Be specific with known landmarks.) _____

ADDENDUM
APPLICATION FOR – ALCOHOL & DRUG TREATMENT PROGRAMS
(Not Children’s Residential Program)

APPLICATION FOR: _____ License (Residential Treatment Program)
_____ Certificate of Approval (Non-Residential Treatment Program)

FACILITY ADDRESS/PHONE (If different from previous): _____ / PHONE: _____

CATCHMENT AREA: (Geographic Area Served): _____

CONTACT PERSON (If different from previous): _____

**Attach additional sheets for multiple sites if necessary.*

CHECK EACH COMPONENT TO BE REVIEWED:

RESIDENTIAL LICENSE: (Service)

- _____ Detox, Medical Model----Number of Beds _____
- _____ Detox, Social Setting -----Number of Beds _____
- _____ Shelter----Number of Beds _____
- _____ Extended Shelter---- Number of Beds _____
- _____ Assisted – Medical Model----- Number of Beds _____
- _____ Extended Care Residential Rehab--- Number of Beds _____
- _____ Halfway House--- Number of Beds _____

SERVICE:

___ Outpatient Care ___ Non-Residential Rehab ___ DEEP-Driver Ed. Evaluation Program ___ Methadone Treatment

ITEMS FOR SUBMISSION

1. Completed Application
2. Application Fee – **\$50.00** Non-Refundable application processing fee, and;
 - a. **\$50.00** For Each Service Checked Off Above (new and renewal applications);
 - b. **\$25.00** Fee to Add A Service to an Existing Site (\$25.00 per each new service)
 - c. **\$25.00** Fee to Add Each New Site (\$25.00 per each new site)

Make check payable to: TREASURER, STATE OF MAINE

3. Fire Inspection Form (Required for ALL New Sites)
4. Organizational Chart
5. List of Governing Body Members/Offices Held/Addresses
6. Staff Roster
7. Program Descriptions
8. Program Admission Criteria for each program
9. Any new or changed policies
10. Submit current water test for each site not on public water

In addition, first time applicants must also submit:

1. Articles of Incorporation
2. Assurance of Compliance (ADA/EEO)
3. Complete Policy and Procedure Manual
4. Sample Client File

WAIVER / EXCEPTION REQUEST OR RE-REQUEST (If applicable)

I/We have received and read the rules for the licensing process. I/We understand that this application authorizes representatives of the Department of Health and Human Services and the State Fire Marshal's Office (if applicable) to make such visits and inspections as may be necessary to ensure that the facility is in compliance with the laws pertaining to the operation of such facilities.

I/We also understand that the signing of this application effectively serves as a release of information and gives permission to the Department of Health and Human Services to obtain any criminal or protective records information which may be on file in any Country, State or Federal Office. I/We understand any falsification of statement may be grounds for denial.

I/We further certify that all information contained in this application (including Addendum) is complete and accurate.

ORIGINAL SIGNATURES REQUIRED:

_____/ DATE: _____
Applicant/Operator/Administrator

Type or Print Name

_____/ DATE: _____
2ND Applicant (If Applicable)

Type or Print Name

_____/ DATE: _____
Board President (If Applicable)

Type or Print Name

Send completed application to:

Department of Health and Human Services
DLRS – SHS #11
Behavioral Health Program
41 Anthony Avenue, 2nd Floor
Augusta, ME 04333-0011

Phone: (207) 287-4399

Fax: (207) 287-9252

TTY: (800) 606-0215