

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 LEON SULLIVAN WAY
CHARLESTON, WEST VIRGINIA 25301**

**AMENDED APPLICATION FOR LICENSE
TO PROVIDE BEHAVIORAL HEALTH SERVICES –
GROUP RESIDENTIAL FACILITY
FOR CHILDREN**

INSTRUCTIONS:

Please read carefully and complete this application in accordance with instructions (use typewriter or print legibly with permanent types of ink).

- Application for license may be made by any political subdivision or by any person, association or corporation.
- Please complete a Page 4 for each service provision or residential location/building operated by the applicant. Please do not submit more than one Page 4 for each building.
- The application shall be verified before an officer of the State authorized to administer oaths, by the person, or by a member of the firm or association or an officer of the corporation making this application.
- This application must be accompanied by a check or money order payable to the West Virginia Department of Health and Human Resources in the amount of ten dollars (\$10.00).

NAME AND LOCATION

Name of Center/Agency: _____

Administrative Mailing Address: _____

Administrative Physical Location: _____

Telephone Number: _____ Fax Number: _____

FEIN#: _____ E-Mail Address: _____

(To be used for the licensure process)

MANAGEMENT AND PERSONNEL OF INSTITUTION

Give exact name of Individual, Partnership, Corporation or Organization Operating Center/Agency:

List Names and Addresses of Any Persons Who, as a Stock Holder or Otherwise, Have a Proprietary Interest of Five (5%) Percent or More in the Center/Agency:

Give Name of Governing Body (Board of Directors, Trustees, Etc.):

List Name and Address of Officers (with Titles) and Members of Governing Board:

	Name	Address	Title
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Give Name and Title of Center/Agency Director:

Give Name and Title of Residential Facility Director, if other than Center/Agency Director:

**REQUESTED CHANGE TO CURRENT
BEHAVIORAL HEALTH CENTER LICENSE**

Please describe below requested change (or changes) to the current license, i.e., adding new building or a change in bed capacity. For any service change (or changes) as currently licensed, a Certification of Need (CON) or a decision of non-reviewability must be rendered from the Health Care Authority. Please indicate below the CON File number(s) and date(s) for any change(s).

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Requested change:

Date of anticipated service change or occupancy:

CON File #:

Date:

Please indicate below any service locations or facilities that are to be dropped from the Center's license.

If the change (or changes) is a residential building, please complete a Page 4. Please do not complete a Page 4, if the change (or changes) is an administrative or non-residential building.

FACILITY INFORMATION
(Please complete a Page 4 for each of the residential buildings on campus.)

Name of Building:		Telephone Number:			
Street Address:		County:			
City/State/Zip Code:		Ownership of Building:			
Type of Construction:		# of Stories:	Gross Square Footage:		
Total number of beds available in this building:		Is building sprinklered?	<input type="checkbox"/>	Yes	<input type="checkbox"/>
				No	

POPULATION SERVED (check all that apply):

<input type="checkbox"/>	Alcohol/Substance Abusers	<input type="checkbox"/>	Mentally Ill/Behaviorally Disturbed	<input type="checkbox"/>	Mentally Retarded/Developmentally Disabled (MR/DD)
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AGE RANGE OF CHILDREN SERVED (check all that apply):

<input type="checkbox"/>	Children 2-11	<input type="checkbox"/>	Children 12-18	<input type="checkbox"/>	Children 18-21
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TYPE OF SERVICES PROVIDED BY NUMBER OF BEDS:

Type of Service	# of Beds	Type of Service	# of Beds
Level I Facility		Psychiatric Residential Treatment Facility (PRTF)	
Level II Facility		Respite	
Level III Facility		Shelter	
Intermediate Care Facility (ICF/MR)		Other (please describe):	

TYPE OF EDUCATIONAL SERVICES PROVIDED (check all that apply):

<input type="checkbox"/>	Public School	<input type="checkbox"/>	Other (please describe):
<input type="checkbox"/>	On-Ground School		

APPLICANT

_____, 20____

Signature of Individual/Administrative Officer:

Title or Position:

If other than Individual or Administrative Officer:

Name

Address

VERIFICATION

STATE OF WEST VIRGINIA)

) ss

County of _____)

_____, being by me duly sworn on his/her oath,
deposes and says that he/she has read the foregoing application and knows the contents thereof: that
the statements concerning the above named center/agency, therein contained, are correct and true of
his/her own knowledge.

(Signature of Individual/Administrative Officer)

Subscribed and sworn to before me this

_____ day of _____, 20_____.

Notary Public

My Commission expires _____.