

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 LEON SULLIVAN WAY
CHARLESTON, WEST VIRGINIA 25301-1713**

**INITIAL OR RENEWAL 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 residential building operating under one residential child care license (e.g., one for each of the residential buildings on a campus, one for each building utilized for residential services).
- 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: _____

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:

BUILDINGS OWNED OR LEASED BY THE CENTER ON CAMPUS GROUNDS

List below addresses and phone numbers for all buildings on Center grounds. Indicate use of property by checking all boxes that apply. (Attach a separate listing and/or copy and complete as many Page 3s as necessary.) Only complete Page 4 for residential buildings.

Building	Use of Property
1. Building: _____ Address: _____ _____ Phone: _____	Administrative Location
	Licensed Residence*
	Other (please describe, i.e., gymnasium, dining hall, school, etc.):
2. Building: _____ Address: _____ _____ Phone: _____	Administrative Location
	Licensed Residence*
	Other (please describe, i.e., gymnasium, dining hall, school, etc.):
3. Building: _____ Address: _____ _____ Phone: _____	Administrative Location
	Licensed Residence*
	Other (please describe, i.e., gymnasium, dining hall, school, etc.):

***FOR ALL BUILDINGS INDICATED AS A LICENSED RESIDENCE, PLEASE COMPLETE A PAGE 4.**

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	No <input type="checkbox"/>

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 _____.