

**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 -
SPECIALIZED FOSTER CARE/TRANSITIONAL LIVING
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.
- 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:

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

Please describe below requested change (or changes) to the current license, i.e., adding new administrative office. 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 administrative offices that are to be dropped from the Center's license.

ADMINISTRATIVE OFFICES

Please list all offices with addresses/telephone numbers from which you provide services to children in specialized foster care and/or transitional living:

1. Office: _____
Address: _____

Phone: _____

5. Office: _____
Address: _____

Phone: _____

2. Office: _____
Address: _____

Phone: _____

6. Office: _____
Address: _____

Phone: _____

3. Office: _____
Address: _____

Phone: _____

7. Office: _____
Address: _____

Phone: _____

4. Office: _____
Address: _____

Phone: _____

8. Office: _____
Address: _____

Phone: _____

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 _____.