STATE OF 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

This form may be completed online, printed and mailed to the address listed above.

INSTRUCTIONS: Please read carefully and complete this application in accordance with the instructions below. Failure to complete the application in full may result in delay of license being issued.

1. Application for license may be made by any entity that provides behavioral health services. For exceptions, see §64-11-3.7.a. - §64-11-3.7.k.
2. Management and Personnel of Institution: Give the names, addresses, type of ownership, governing body, board of directors, officers and titles.
3. Complete a Page 3 for each new service provision or residential location / building operated by the applicant.
4. The application must be completed by the Individual Owner or Administrative Officer who must sign Page 4. This signature must be verified / acknowledged by a West Virginia Notary Public.
5. 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).

NOTE: Prior to an amended license being issued, the Center must be in compliance with the Health Care Financial Disclosure Act (W.Va. Code §16-5F-1 et seq.), the Financial Disclosure Rule (65CSR13) and the Unemployment Compensation/Workers' Compensation requirements (96CSR1).

Please Complete Checklist

☐ Application Signed ☐ Application Notarized ☐ Application Fee Enclosed (payable to WVDHHR)

IDENTIFYING INFORMATION

Name of Center

Administrative Mailing Address

City State Zip Code

Administrative Physical Address

City State Zip Code

Phone Number Fax Number

E-mail Address

(To be used for the licensure process)

The Center's FEIN Number:

Current Date________

MANAGEMENT AND PERSONNEL OF CENTER

Give exact legal name of Individual, Partnership, Corporation or Organization Operating Center

____

Select Business Type [ ] **Please choose one:** [ ]

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 or Attach Separate Sheet

____

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

____

List Name and Address of Officers (with Titles) and Members of Governing Board Below or Attach Separate Sheet

Name	Address	Title

Give Name and Title of Center Administrator Below

____

Requested Change(s) to Current Behavioral Health Center License

Please describe below the requested change(s) to the current license, i.e., adding new service location/unit or a change in bed capacity. For any service change(s) as currently licensed, a Certificate 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: ________

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 service location or residential facility which is owned or leased by the Center, please complete a Page 3 for the service location / facility.

OWNED, LEASED OR OPERATED BUILDING / SERVICE

(Please complete a PAGE 3 for EACH service location / units-for additional copies of page 3, click here)

Name of Bldg ____________________

Address ____________________

City ____________ **State** ______ **Zip Code** ________ **County** ____________

Phone Number [ ] **Fax Number** [ ]

Ownership of Building ____________________

Type of Construction: ____________ **Square Footage** ________ **Number of Stories** ______

Sprinkled? ☐ Yes ☐ No **If 24-hour adult residential, are ALL consumers capable of self-preservation?** ☐ Yes ☐ No

DISABILITY SERVED *(Check ALL that APPLY)*
◯ Intellectually Disabled (ID)
◯ Mentally Ill (MI)
◯ Substance Abuse (SA)

AGE RANGE OF CONSUMERS SERVED *(Check ALL that APPLY)*
◯ Children 2-17
◯ Adults 18 +
◯ Adults 60+

TYPE OF SERVICES PROVIDED *(Check ONLY the service(s) provided via this building)*	
◯ Administrative Office	◯ I/DD Waiver Services
◯ Employment Services	◯ Outpatient Services
◯ Day Treatment - Intellectually Disabled	◯ Sheltered Workshop
◯ Day Treatment - Mentally Ill	

Total # of Consumers who Receive Services from this Building [Open Cases/Files ONLY]: ________

Please check all that apply & enter number of beds

◯ **Residential - ID** ◯ **Residential - MI** ◯ **Residential - SA**

TYPE OF RESIDENTIAL SERVICE			
Crisis Residential Unit		Detox Services	
Group Residential		Public Inebriate Shelter	
Respite		Other (please specify):	
Individual Apartments (Facility-Owned)			
Intermediate Care Facility / Individuals who are Intellectually Disabled (ICF/IID)			

APPLICANT INFORMATION

Date: __________________

Signature of Individual/Administrative Officer:

____

Title or Position: ____

If other than Individual or Administrative Officer:

Name	Address

NOTARY VERIFICATION

STATE OF WEST VIRGINIA

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 Applicant ______________________________________

Subscribed and sworn to before me this __________ day of _______________, 20__.

____
(Notary Public)

My Commission Expires: ________________________