

**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES**



**BRIAN SCHWEITZER
GOVERNOR**

**JOAN MILES
DIRECTOR**

STATE OF MONTANA

<http://www.dphhs.mt.gov/>
(406) 444-3964
FAX: (406) 444-9389

555 Fuller
P.O. Box 202905
HELENA, MT 59620-2905

**APPLICATION REQUEST FOR
APPROVAL OF CHEMICAL DEPENDENCY TREATMENT SERVICES**

PLEASE TYPE OR PRINT CLEARLY, IF YOU REQUIRE ADDITIONAL SPACE PLEASE ATTACH SEPARATE PAPERS.

1. Applicant Agency Name: _____

Address: _____

Telephone: _____

FAX: _____ E-mail: _____

2. Project Director (or contact person)

Name: _____

Address: _____

Telephone: _____

Cell phone: _____ E-mail: _____

3. Project Title: _____

4. Type of Agency:

Federal Government: _____ State Government: _____ Local Government: _____

Private: _____ Private Tax Exempt _____ (include IRS no.) _____

5. List geographic area [County(ies)] to be served: _____

6. Indicate type of services to be provided (if Residential, also indicate proposed number of beds):

Detox No. Beds _____ Inpatient No. Beds _____ Day Treatment _____

Transitional Living No. Beds _____ Intensive Outpatient Outpatient

Educational Course (DUI, MDD or MIP) Specify _____

7. List the proposed sources and amount of funding:

Federal _____ State _____ County _____ Local _____

Private _____ Private _____ Third Party of Client Fees _____

Other (specify) _____

Projected Total Annual Budget of Project: _____

8. List appropriate number of staff required for project:
Administrative Staff _____ Direct Services Staff _____ TOTAL Staff _____

9. Is the above organization or project identified and/or addressed in the County (ies)
[Listed in item 5] Chemical Dependency Plan(s)?
Yes _____ No _____ If no, please explain _____

10. Document community need for the proposed project, indicating what procedures were used to determine this need. If requesting approval for inpatient, please submit a Certificate of Need approval from the Department of Public Health and Human Services, Quality Assurance Division, CON Administrative Officer Pamela Sourbeer at (406) 444-9510. _____

11. What is the projected demand for the services to be provided? How was this determined?

12. What alternatives were considered for meeting identified needs, how were these evaluated and why was the proposed alternatives chosen? _____

13. Describe Target Groups and identify specific recipients of the services, (i.e. youth, women, elderly, ethnic minority, general populace, etc.) _____

14. Estimate the number of clients the proposed project will serve during a one year time period by service component. _____

15. Are other chemical dependency services available within this service area?

Yes____No____ If yes:

A. List other providers:_____

B. Explain why this project is needed rather than expanding or utilizing existing services:_____

C. Explain how the project will be integrated into the existing Chemical Dependency and other health care services, i.e. have coordination or cooperative arrangements been made with other programs or agencies? What impact will this project have on similar existing chemical dependency programs?_____

D. How will the project improve access to the present Chemical Dependency Service System without undue increases in cost?_____

16. Indicate target dates for commencement of operations_____

NOTE: THE ADDICTIVE & MENTAL DISORDERS DIVISION MAY REQUIRE CLARIFICATION OF ALL THE ABOVE INFORMATION.

17. I certify that all information contained on or attached with this application is true and complete to the best of my knowledge.

Signed

Title

Date