

MONTANA DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Quality Assurance Division - Licensure Bureau

2401 Colonial Drive - 2nd Floor

P.O. Box 202953

Helena, MT 59620-2953

**APPLICATION FOR MONTANA STATE HEALTH CARE FACILITY/SERVICE LICENSE
MENTAL HEALTH CENTER**

Initial Application **Renewal** **Adding or Changing Endorsements***
(complete page 1 and 2 if adding or changing endorsements)

ORGANIZATION NAME _____

ADMINISTRATIVE OFFICE ADDRESS _____

CITY _____ COUNTY _____

ADMINISTRATIVE OFFICE TELEPHONE NUMBER _____

Name of Applicant/Administrator _____

Administrator Address _____

Name of Chairman of Board (if any) _____

Information on ownership, contract, or lease agreement if operated by a person other than the owner:

- A partnership, firm or association--list every member thereof.**
- A corporation--list the name and address thereof and the names of its officers.**
- State Affiliated Organization**

Name	Address

(please attach additional sheets if necessary)

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List the name and professional license number of the Mental Health Center’s medical director.

Name _____ License No _____

List names and professional license numbers of all licensed professionals employed by your Organization.

NAME	LICENSE NO.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check the areas of endorsement for which your organization is requesting licensure, (ARM 37.106.1906):

- _____ Child and Adolescent Intensive Care Management
- _____ Adult Intensive Case Management
- _____ Child and Adolescent Day Treatment
- _____ Adult Day Treatment Program
- _____ Foster Care for Adults with Mental Illness
- _____ Comprehensive School and Community Treatment Program (CSCT)
- _____ Inpatient Crisis Stabilization Program*
- _____ Mental Health Group Home*
- _____ Outpatient Crisis Response Facility*
- _____ Secured Crisis Stabilization Facility (SCSF)*

**For each Inpatient Crisis Stabilization Program, Mental Health Group Home, Outpatient Crisis Response Facility and Secured Crisis Stabilization Facility provide the name, address, phone number, name of supervisor, and the number of beds.*

Please include the following with your application:

- **All Mental Health Center Site addresses**—please attach a listing
- **Mental Health Center Policies and Procedures (only required at the time of initial application or upon addition of a new endorsement)**



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I certify that all information submitted to DPHHS is true and correct. This license application for a Mental Health Center is hereby submitted under the provisions of Section 50-5-101 through 50-5-231, MCA.

DATE _____ SIGNED _____

TITLE _____

ADDRESS _____

Please enclose a check, money order or draft made payable to the Department of Public Health and Human Services to cover the license fee. The fee is determined as follows:

- (a) facilities with 20 beds or less -- \$20.00;
- (b) facilities with 21 beds or more -- \$1.00 per bed;
- (c) facilities with no beds -- \$20.00.

This fee will be deposited in the State Treasury and is non-refundable.