

## Application For Licensing to Provide SUBSTANCE ABUSE TREATMENT SERVICES

Submission Date (Month/Day/Year)
New Application
Renewal
Anticipated
Anticipated Relocation Date:
☐ Change in Organization

MIT ETAMILIES.COM								L Cl	nange in Organization
I. SERVICE PROVIDER I  1. Service Provider Legal Name (if mu				ADOUADTEDS	nama)	2 F4	ederal ID a	#	National Provider ID (NPI)
1. Service Flovider Legal Name (ii iiiu	itipie iocatio	1115, 61116	I CORPORATE HE	ADQUARTERS	name)	2.16	suciai ID 1	#	3. National Flovider ID (NFI)
4. Name of the Service Provider's Ow	ner					5. Cor	porate We	ebsite Add	ress
6. Corporate / Owner's Mailing Addres	SS								
6a. City			6b. State		6c. Zi	p Code	9	6d. Cour	nty
7. Circuit/Region		8. Tele	3. Telephone (Area Code & Number)			9. Fax Te		Telephone (Area Code and Number)	
10. Physical Address (If different from	mailing ad	dress)							
10a. City			10b. State		10c. Z	ip Cod	le	10d. Cou	unty
40- Describer Deint of Court of E									
10e. Provider Point of Contact E			anization ann	royed by th	no Doi	nartm	ont? If	so plose	eo includo tho
<ol> <li>Is the applicant accredited b accrediting organization's inf</li> </ol>				noved by ti	ie Del	parum	entr ii s	so, pieas	se include the
Name of Accrediting Organ	nization:_		_						
Three-Year	One-Y	ear	A	ccreditatio	n Exp	iratior	n Date:_		
For renewals, please submit accreditation status.	the most	recen	t accreditatio	n survey r	eport	with	this ap	plication	n including changes in
12. Type of Legal Entity: Check	the appli	cable l	oox(es) below	:					
Profit; check type of "For	Profit" be	elow:			Non-F	Profit			
Please check applicable	boxes:				Forei	gn Lin	nited Lia	bility Pa	rtnership
Private Practitione	er								
Faith-Based Provi	ider								
Community Substa	ance Abu	se Coa	llition						
13. Are you currently contracted	with the	Depart	ment of	14. Do yo	u acce	ept the	e followi	ng recipi	ents?
Children and Families?				Medic	caid	lr	ndigent F	Persons	Pregnant Women
∐Yes ∐No									
15. Is the agency incorporated w	vith the St	ate of	Florida?						**Non-Profit
∐Yes ∐No				Corpo					of IRS Form 990.
						Yes	No	)	

If incorporated, submit the names of the owner, board members, officers and shareholders. (*Must be Background screened per Section 397.4073, F.S., and Chapter 453, F.S.)				
17. Name of Owner*				
18a. Name of the Chief Executive Officer*	18b. Chief Executive Officer's Email Address			
19. Name of the Chief Financial Officer*				
20. Name of the Staff Training Coordinator				
21. Name and professional license number of Medical Director	r (applies to addictions receiving facilities, detoxification.			
intensive inpatient treatment, residential treatment, day or r	night treatment, and medication-assisted treatment for opioid			
addiction). Submit proof of a valid medical license accomp	anied by, including but not limited to, the following			
documentation:	veician named on the medical license; and			
a. A copy of photo identification matching that of the ph	(1) employed or contracted by the provider as a medical			
	the is acting (addictions receiving facility, detoxification,			
intensive inpatient treatment, residential treatment, c	or methadone medication-assisted treatment); and (2)			
knowledgeable of the limit to acting as medical direc	tor for no more than 10 facilities within a 200-mile radius.			
Name of Medical Director*:	License Number:			

**EXEMPTIONS:** Pursuant to Chapter 397.4014, F.S., Inmate Substance Abuse Programs are exempt from providing specific documentation in the application process. "Inmate Substance Abuse Services" means any service component as defined in S. 397.311 provided directly by the Department of Corrections and licensed and regulated by the Department of Children and Families pursuant to Chapter 397.752 – 397.754, F.S. or provided through contractual arrangements with a service provider licensed pursuant to Chapter 397, Part VIII, or any self-help program or volunteer support group operating for inmates.

An application without the applicable licensure fee as required under Section 397.407, Florida Statutes and Section 65D-30.0035, Florida Administrative Code, will be returned to the applicant. An application for renewal of a regular license must be submitted to the Department at least 90 calendar days before the license expires. A late fee of \$100 per license component shall be assessed for the late filing of an application as required under Section 397.407(2) Florida Statutes.

Please make check payable to the Florida Department of Children and Families.

Signature of the Chief Exec	utive Officer (Original signature	only)		Pate (month, day, year)
Renewal Attestation				
☐ Local Law Enforcem	e Manual t Screening (Must be resubm ent Check (Must be resubm ied Professional(s) (Must re	nitted every 5 yea	ars) ars)	pply):
PLADS in order to be proce must be submitted on an an	rred, the Provider must essed with the renewal a nual basis. For new appl	application. All	other required do	ocumentation for renewa
Note: If changes have occu PLADS in order to be proce must be submitted on an an to process your application	rred, the Provider must essed with the renewal a nual basis. For new appl	application. All	other required do ired documents m	ocumentation for renewa ust be submitted in orde
Note: If changes have occu PLADS in order to be proce must be submitted on an an to process your application	rred, the Provider must essed with the renewal a nual basis. For new appli cer (Original signature only)	application. All icants, all requ	other required do ired documents m	ocumentation for renewa
Note: If changes have occur PLADS in order to be process must be submitted on an an accordance of the Chief Executive Offic II. PROGRAM COMPON Name of Program (e.g., Adult Outpat	rred, the Provider must essed with the renewal a nual basis. For new application.  Deer (Original signature only)	application. All required icants, all required to the control of t	other required do ired documents m	th, day, year)  Telephone (Area Code & Number
Service Fee/Service  Note: If changes have occu PLADS in order to be proce must be submitted on an an to process your application  Signature of the Chief Executive Offic  II. PROGRAM COMPON  Name of Program (e.g., Adult Outpat)  Street Address  City	rred, the Provider must essed with the renewal a nual basis. For new application.  Deer (Original signature only)	application. All required icants, all required to the control of t	other required do ired documents m  Date (month)	th, day, year)  Telephone (Area Code & Number
Note: If changes have occur PLADS in order to be processured to be processured on an an opposite of the Chief Executive Office II. PROGRAM COMPON Name of Program (e.g., Adult Outpate Street Address City	rred, the Provider must essed with the renewal a nual basis. For new application of the control	- Location 1 Treatment, Outread  4. Building Nu  7. Zip Code	Date (months)  Ch Prevention, etc.)  8. Circuit/Region	th, day, year)  Telephone (Area Code & Number Lite, etc.
Note: If changes have occur PLADS in order to be process nust be submitted on an an oprocess your application Gignature of the Chief Executive Offic II. PROGRAM COMPON Name of Program (e.g., Adult Outpat) Street Address	rred, the Provider must essed with the renewal a nual basis. For new application (Original signature only)  IENT INFORMATION - tient Treatment, Youth Residential  6. State	- Location 1 Treatment, Outread  4. Building Nu  7. Zip Code	Date (months)  Ch Prevention, etc.)  2.  mber, Room Number, St	th, day, year)  Telephone (Area Code & Number Lite, etc.

14a. Addictions Receiving Facility:	14d. Residential Programs:	14i. Aftercare Programs:	
Please check if you are seeking	Level 1; Total Bed Capacity:	Aftercare	
designation and a license	Level 2; Total Bed Capacity:	14i Intervention Brograms	
Addictions Receiving Facility	Level 3; Total Bed Capacity:	14j. Intervention Programs:	
Juvenile Addictions Receiving Facility	Level 4; Total Bed Capacity:	Case Management General Intervention	
Integrated	Licensed Bed Capacity:	Employee Assistance Program	
Licensed Bed Capacity:	14e. Day or Night Treatment Programs	Treatment Alternatives for Safer	
14b. Detoxification Programs:	with Community Housing:	Communities (TASC)	
Inpatient Detoxification	Day or Night Treatment Programs with Community Housing	14k. Prevention Programs:	
Licensed Bed Capacity:	Location of Housing:	Universal Direct	
Inpatient Methadone Detoxification	Total Bed Capacity:	Selective	
Licensed Bed Capacity:	Total Boa Gapaony.	Indicated	
Outpatient Detoxification	14f. Day or Night Treatment Programs:		
Outpatient Methadone	Day or Night Treatment		
Detoxification	14g. Intensive Outpatient Programs:	14l. Medication-Assisted Treatment for Opioid Addiction Programs:	
14c. Intensive Inpatient Treatment Programs:	Intensive Outpatient Treatment	Medication and Methadone Maintenance Treatment	
Intensive Inpatient Treatment	14h. Outpatient Programs:	Medication Unit	
Licensed Bed Capacity:	Outpatient Treatment	Maximum Capacity:	

15. Hours during wi	nich the pro	ogram is open:	16. Submit with this application evidence of compliance for applicable		
Monday:	to	Closed	areas below (including applicable expiration date): <u>Expiration Date</u>		
Tuesday:	to	Closed	Fire and Safety:		
Wednesday:	to	Closed	Health Standards: Facility Inspection: Yes □ No □ N/A		
Thursday:	to		Food Services: Yes No N/A		
•		<u>—</u>	Zoning Compliance: Yes No		
Friday:	to	Closed	Property Insurance: Yes  No		
Saturday:	to	Closed	Professional Liability Yes No		
Sunday:	to	Closed	Recovery Residence Referral Log: Yes No N/A		
			Affidavit of Good Moral Character:  Yes No		
			Policy & Procedure Manual: Yes No N/A		
			Current Organizational Chart: Yes No		
			Level 2 Background Screening: Yes No		
			Local Law Enforcement Check: Yes No		
			Verification of Qualified Professional(s):☐ Yes ☐ No		
			Treatment Resource Attestation: Yes No		
			Service Fee Schedule:  Yes  No		
			Policies regarding an Individual's financial responsibility:		
			☐ Yes ☐ No		
			Provide proof of the availability and provision of meals for the		
			following:  Addictions receiving facilities: ☐ Yes ☐ No		
			Day and Night Treatment, If applicable: Yes No		
			Residential Treatment: ☐ Yes ☐ No Day and Night Treatment, If applicable: ☐ Yes ☐ No		
			Day or night treatment with community housing: ☐ Yes ☐ No		
			Note: Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.		
II. PROGRAM	COMPO	NENT INFORMATION -	- Location 1 (Continued)		
		ment (i.e., programs which use ments with this application.	methadone or other medications for treating opioid addiction). Submit		
State Met	hadone Au	thority			
☐ Board of F	Pharmacy -	- submit a copy of the pharmacy	y permit		
Verification	n of the se	rvices of a consultant pharmacis	st		
Not Applic	cable				
	Please Note: Drug Enforcement Agency (DEA) registration and verification of Substance Abuse and Mental Health Services Administration (SAMHSA) certification are required prior to the issuance of a regular license.				
18 Have all staff ar	nd voluntee	rs who have direct contact with	clients under the 19. What is the maximum number of clients that can		
age of 18 years	or adults v	with developmental disabilities bece with section 397.4073(1)(a),	een fingerprinted be served in this component on a given day?		

Yes No Not Applicable	
20. Target Population:  White (Non-Hispanic) American Indian Hispanic Bla  Other (please describe):	ack (Non-Hispanic)
Adolescents Visually Homeless Older A Criminal Justice-Involved Adults Co-occi Juvenile Justice-Involved Youth	DS g Impaired y Impaired Adults
22. List the complete names of agencies and practitioners with which you have we and check the type of business relationship:  a.	ct Subcontract Other (specify): ct Subcontract Other (specify): ct Subcontract Other (specify): ct Subcontract Other (specify):
23. List the sources of revenue you receive by name and check the type of funds a. State Federal b. State Federal c. State Federal d. State Federal e. State Federal  State Federal  State Federal  State Federal	Fees Private Other (specify):    Fees Private Other (specify):   Fees Private Other (specify):   Fees Private Other (specify):   Fees Private Other (specify):   Fees Private Other (specify):   Fees Private Other (specify):

## II. PROGRAM COMPONENT INFORMATION – Location 2

1. Name of Program (e.g., Adult Outpatient Treat	tment, Youth Residential	Γreatment, Outre	ach Preve	ention, etc.) 2. Telephon	e (Area Code & Number)	
3. Street Address		4. Building Number, Room Number, Suite, etc.				
5. City	7. Zip Code	8. Cii	rcuit/Region	9. County		
10. Current License Number	Florida	11. Current Li	icense Ex	piration Date (MM/DD/Y)	()	
12. Name of Program Director*	13. Name of Clinical Director*			rector*		
14. Type of Service Component (please c	heck all that apply fo	or this location	n):			
14a. Addictions Receiving Facility:	14d. Residential Pro	grams:		14i. Aftercare Progr	ams:	
Please check if you are seeking	Level 1; Total	Bed Capacity:		Aftercare		
designation and a license	Level 2; Total	Bed Capacity:				
Addictions Receiving Facility	Level 3; Total			14j. Intervention Pro	_	
Juvenile Addictions Receiving	Level 4; Total			Case Manage	ement	
Facility				General Interv	vention	
Integrated	Licensed Bed (	Capacity:	_	Employee Assistance Program		
Licensed Bed Capacity:	14e. <b>Day or Night Tr</b>	reatment Proc	arams	Treatment Alt	ernatives for Safer	
	with Communit		jiums	Communities (TASC)		
14b. <b>Detoxification Programs:</b>	Day or Night T	-	grams			
Inpatient Detoxification	with Commun	•		14k. <b>Prevention Pro</b>	•	
Licensed Bed Capacity:	Location of Hou	using:		Universal Dire	ect	
Inpatient Methadone	Total Bed Capa			Selective		
Detoxification	Total Bod Gape			Indicated		
Licensed Bed Capacity:	14f. Day or Night Tro	eatment Prog	rams:			
Outpatient Detoxification	☐ Day or Night T	reatment				
Outpatient Methadone Detoxification	14g. Intensive Outpa			14l. Medication-Ass Opioid Addiction	on Programs:	
	Intensive Outp	oatient Treatme	ent	Medication an		
14c. Intensive Inpatient Treatment	1411 0 4 45 45			Maintenance		
Programs:	14h. <b>Outpatient Pro</b> g	-		Medication U		
Intensive Inpatient Treatment Licensed Bed Capacity:	Outpatient Tre	eatment		Maximum Ca	pacity:	

15. Hours during w	hich the pro	gram is open:	16. Submit with this application evidence of compliance for applicable
Monday:	to	Closed	areas below (including the expiration date): <u>Expiration Date</u>
Tuesday:	to	Closed	Fire and Safety:
Wednesday:	to	Closed	Health Standards:  Facility Inspection: Yes No N/A
Thursday:	to	Closed	Food Services:
Friday:	to	Closed	Zoning Compliance: Yes No
Saturday:	to	Closed	Property Insurance: Yes No
Sunday:	to	Closed	Professional Liability Yes No
			Recovery Residence Referral Log: Yes No N/A
			Affidavit of Good Moral Character: Yes No
			Policy & Procedure Manual: Yes No N/A
			Current Organizational Chart: Yes No
			Level 2 Background Screening: Yes No
			Local Law Enforcement Check: Yes No
			Verification of Qualified Professional(s): Yes No
			Service Fee Schedule:  Yes  No
			Treatment Resource Attestation:   Yes   No
			Policies regarding an Individual's financial responsibility:
			☐ Yes ☐ No
			Provide proof of the availability and provision of meals for the
			following:  Addictions receiving facilities: ☐ Yes ☐ No  Day and Night Treatment, If applicable: ☐ Yes ☐ No
			Residential Treatment: ☐ Yes ☐ No Day and Night Treatment, If applicable: ☐ Yes ☐ No
			Day or night treatment with community housing:☐ Yes ☐ No
			<b>Note:</b> Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.
			- Location 2 (Continued)
		nent (i.e., programs which use nents with this application.	methadone or other medications for treating opioid addiction). Submit
	thadone Aut		
Board of	Pharmacy –	submit a copy of the pharmac	y permit
☐ Verification	on of the ser	vices of a consultant pharmaci	st
☐ Not Appli	cable		
			n and verification of Substance Abuse and Mental Health Services red prior to the issuance of a regular license.

18. Have all staff and volunteers who have dir the age of 18 years or adults with develop fingerprinted and screened in accordance Florida Statutes?	mental disabilities l	peen	19. What is the maximum not be served in this compo	
Yes No Not Ap	plicable			
Other (please describe):			lack (Non-Hispanic)	
21. List any special population group targeted justice clients, etc.)	for services (e.g., h	nearing impaire	ed, pregnant alcoholics or add	dicts, youth, criminal
Children		HIV/AI	os	
Women		Hearing	g Impaired	
Adolescents		☐ Visually	/ Impaired	
Homeless		Older A	dults	
Criminal Justice-Involved Adults		Co-occ	urring	
Juvenile Justice-Involved Youth		Intrave	nous Drug Users	
Pregnant and Post-Partum Women		Other (	please describe other group)	:
Pregnant and Post-Partum Adolesce	ents			
22. List the complete names of agencies or presubcontracts, and check the type of business.  a. b. c. d. e.  23. List the sources of revenue you receive bea. b. c. d. e.	ess relationship: Agreemer Agreemer Agreemer Agreemer Agreemer	nt Contract nt Contract nt Contract nt Contract nt Contract nt Contract	ct Subcontract Ott ct Private Ott ds, e.g., state funds, federal f Fees Private Ott Fees Private Ott Fees Private Ott Fees Private Ott	ner (specify): ner (specify): ner (specify): ner (specify): ner (specify):
II. PROGRAM COMPONENT INFO	DRMATION - L	ocation 3		
Name of Program (e.g., Adult Outpatient Treatmen	nt. Youth Residential T	reatment. Outrea	ch Prevention, etc.)   2. Telephon	e (Area Code & Number)
		·		,
3. Street Address		4. Building Nun	nber, Room Number, Suite, etc.	
5. City	6. State	7. Zip Code	8. Circuit/Region	9. County
10. Current License Number		11. Current Lice	ense Expiration Date (MM/DD/Y	()
12. Name of Program Director*		13. Name of Cl	inical Director*	
14. Type of Service Component (please chec	k all that apply for	r this location	):	

14a. Addictions Receiving Facility:	14d. Residential Programs:	14i. Aftercare Programs:
Please check if you are seeking	Level 1; Total Bed Capacity:	Aftercare
designation and a license	Level 2; Total Bed Capacity:	
Addictions Receiving Facility	Level 3; Total Bed Capacity:	14j. Intervention Programs:
Juvenile Addictions Receiving	Level 4; Total Bed Capacity:	Case Management
Facility		General Intervention
Integrated	Licensed Bed Capacity:	Employee Assistance Program
Licensed Bed Capacity:	14e. Day or Night Treatment Programs	Treatment Alternatives for Safer
44h Batavitiantian Buannama	with Community Housing:	Communities (TASC)
14b. <b>Detoxification Programs:</b>	Day or Night Treatment Programs	
Inpatient Detoxification	with Community Housing	14k. Prevention Programs:
Licensed Bed Capacity:	Location of Housing:	Universal Direct
Inpatient Methadone	Total Bed Capacity:	Selective
Detoxification	· , <del></del>	Indicated
Licensed Bed Capacity:	14f. Day or Night Treatment Programs:	14l. Medication-Assisted Treatment for
Outpatient Detoxification	Day or Night Treatment	Opioid Addiction Programs:
Outpatient Methadone		Medication and Methadone
Detoxification	14g. Intensive Outpatient Programs:	Maintenance Treatment
	Intensive Outpatient Treatment	Medication Unit
14c. Intensive Inpatient Treatment Programs:	14h. Outpatient Programs:	Maximum Capacity:
Intensive Inpatient Treatment	Outpatient Treatment	
· ·		
Licensed Bed Capacity:		

15. Hours during wh	nich the pro	ogram is open:	16. Submit with this application evidence of compliance for applicable
Monday:	to	Closed	areas below (including the expiration date): <u>Expiration Date</u>
Tuesday:	to	Closed	Fire and Safety: Yes No
Wednesday:	to	Closed	Health Standards:  Facility Inspection: Yes No N/A
Thursday:	to	Closed	Food Services: Yes No N/A
Friday:	to	Closed	Zoning Compliance: Yes No
Saturday:	to	Closed	Property Insurance: Yes No
Sunday:	to	Closed	Professional Liability Yes No
			Recovery Residence Referral Log: Yes No N/A
			Affidavit of Good Moral Character: Yes No
			Policy & Procedure Manual: Yes No N/A
			Current Organizational Chart: Yes No
			Level 2 Background Screening: Yes No
			Local Law Enforcement Check: Yes No
			Verification of Qualified Professional(s): Yes No
			Treatment Resource Attestation:  Yes No
			Service Fee Schedule:  Yes  No Policies regarding an Individual's financial responsibility:
			☐ Yes ☐ No
			Provide proof of the availability and provision of meals for the
			following:  Addictions receiving facilities: ☐ Yes ☐ No  Day and Night Treatment, If applicable: ☐ Yes ☐ No
			Residential Treatment:  Yes  No Day and Night Treatment, If applicable:  Yes  No
			Day or night treatment with community housing:☐ Yes ☐ No
			Note: Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.
II. PROGRAM	COMPO	NENT INFORMATION -	- Location 3 (Continued)
		ment (i.e., programs which use ments with this application.	methadone or other medications for treating opioid addiction). Submit
	hadone Au		
☐ Board of F	Pharmacy -	- submit a copy of the pharmac	y permit
Verificatio	n of the se	rvices of a consultant pharmaci	st
☐ Not Applic	cable		
			verification of Substance Abuse and Mental Health Services red prior to the issuance of a regular license.

18. Have all staff and volunteers who have direct contact with clients under the age of 18 years or adults with developmental disabilities been fingerprinted and screened in accordance with section 397.4073(1)(a), Florida Statutes?	19. What is the maximum number of clients that can be served in this component on a given day?
Yes No Not Applicable	
20. Target Population:	
☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ BI	lack (Non-Hispanic)
Other (please describe):	
21. List any special population group targeted for services (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal justice clients, etc.)	
☐ Children ☐ HIV/AID	OS .
☐ Women ☐ Hearing	Impaired
Adolescents Visually Impaired	
☐ Homeless ☐ Older Adults	
Criminal Justice-Involved Adults	
☐ Juvenile Justice-Involved Youth ☐ Intravenous Drug Users	
Pregnant and Post-Partum Women Other (please describe other group):	
Pregnant and Post-Partum Adolescents	
22. List the complete names of agencies and practitioners with which you have written referral agreements, contracts, or subcontracts, and check the type of business relationship:	
a. Agreement Contract	ct Subcontract Other (specify):
b. Agreement Contract	
c. Agreement Contract	
d. Agreement Contract	
d	
23. List the sources of revenue you receive by name and check the type of funds, e.g., state funds, federal funds, fees, etc:	
a. State Federal	Fees Private Other (specify):
b. State Federal	Fees Private Other (specify):
c. State Federal	Fees Private Other (specify):
d. State Federal	Fees Private Other (specify):
e. State Federal	Fees Private Other (specify):