Application For Licensing to Provide SUBSTANCE ABUSE TREATMENT SERVICES

Submission Date (Month/Day/Year)

☐ New Application
☐ Renewal
☐ Relocation
Anticipated Relocation Date:
☐ Change in Organization

I. SERVICE PROVIDER INFORMATION

1. Service Provider Legal Name **(if multiple locations, enter CORPORATE HEADQUARTERS name)**	2. Federal ID #	3. National Provider ID (NPI)

4. Name of the Service Provider's Owner	5. Corporate Website Address

6. Corporate / Owner's Mailing Address			
6a. City	6b. State	6c. Zip Code	6d. County

7. Circuit/Region	8. Telephone (Area Code & Number)	9. Fax Telephone (Area Code and Number)

10. Physical Address (If different from mailing address)			
10a. City	10b. State	10c. Zip Code	10d. County

10e. Provider Point of Contact Email Address:

11. Is the applicant accredited by a certifying organization approved by the Department? If so, please include the accrediting organization's information below:

Name of Accrediting Organization:_____

☐ Three-Year ☐ One-Year Accreditation Expiration Date:_____

For renewals, please submit the most recent accreditation survey report with this application including changes in accreditation status.

12. Type of Legal Entity: Check the applicable box(es) below.

☐ Profit; check type of "For Profit" below:
Please check applicable boxes:
☐ Private Practitioner
☐ Faith-Based Provider
☐ Community Substance Abuse Coalition

☐ Non-Profit
☐ Foreign Limited Liability Partnership

13. Are you currently contracted with the Department of Children and Families?
☐ Yes ☐ No

14. Do you accept the following recipients?
☐ Medicaid ☐ Indigent Persons ☐ Pregnant Women

15. Is the agency incorporated with the State of Florida?
☐ Yes ☐ No

16. If so, is the corporation for profit? **Non-Profit Corporation requires submission 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 (applies to addictions receiving facilities, detoxification, intensive inpatient treatment, residential treatment, day or night treatment, and medication-assisted treatment for opioid addiction). Submit proof of a valid medical license accompanied by, including but not limited to, the following documentation:

a. A copy of photo identification matching that of the physician named on the medical license; and

b. A letter from the physician attesting that he or she is (1) employed or contracted by the provider as a medical director, and specifying for which component he or she is acting (addictions receiving facility, detoxification, intensive inpatient treatment, residential treatment, or methadone medication-assisted treatment); and (2) knowledgeable of the limit to acting as medical director 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 60 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.

I attest that the information provided is true, accurate and complete to the best of my knowledge.

Signature of the Chief Executive Officer (Original signature only) _____ Date (month, day, year) _____

Renewal Attestation

I,_____, attest as follows:

(1) Pursuant to section 408.809, 435.05, 397.4073, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury to meeting the requirements for qualifying employment pursuant to Chapter 408, Part II and Chapter 435 Florida Statute, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(2) Pursuant to section 435.05 Florida Statutes, the applicant has conducted a level 2 background screening on every employee required to be screened under Chapter 408, Part II or Chapter 435 Florida statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screenings standards or obtained an exemption from disqualification from employment.

(3) There have been no changes made to the following (please check all that apply):

- ☐ Policy and Procedure Manual
- ☐ Organizational Chart
- ☐ Verification documentation of current Qualified Professional(s) (Must resubmitted every 3 years)
- ☐ Service Fee/Service Component Schedule

Note: If changes have occurred, the provider must submit the current documentation to the Department via PLADS in order to be processed with the renewal application. All other required documentation for renewal must be submitted on an annual basis. For new applicants, all required documents must be submitted to process your application.

Signature of the Chief Executive Officer (Original signature only) Date (month, day, year)

II. PROGRAM COMPONENT INFORMATION – Location 1

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)			2. Telephone (Area Code & Number)	
3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State Florida	7. Zip Code	8. Circuit/Region	9. County

10. Current License Number	11. Current License Expiration Date (MM/DD/YY)
12. Name of Program Director*	13. Name of Clinical Director*

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated

Licensed Bed Capacity:_____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification

Licensed Bed Capacity:_____

- ☐ Inpatient Methadone Detoxification

Licensed Bed Capacity:_____

- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment

Licensed Bed Capacity:_____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity:_____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity:_____

Licensed Bed Capacity:_____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

Location of Housing:_____

Total Bed Capacity:_____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Universal Direct
- ☐ Selective
- ☐ Indicated

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Medication Unit

Maximum Capacity: _____

15. Hours during which the program is open:

Monday:	to	.....	☐ Closed
Tuesday:	to	.....	☐ Closed
Wednesday:	to	.....	☐ Closed
Thursday:	to	.....	☐ Closed
Friday:	to	.....	☐ Closed
Saturday:	to	.....	☐ Closed
Sunday:	to	.....	☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including applicable expiration date):

Expiration Date

Fire and Safety: ..... ☐ Yes .....

Health Standards:
Facility Inspection: .. ☐ Yes ☐ N/A.....
Food Services:..... ☐ Yes ☐ N/A.....

Zoning Compliance:.... ☐ Yes .....

Property Insurance: .... ☐ Yes .....

Professional Liability Insurance ... ☐ Yes .....

Recovery Residence Referral Log: ☐ Yes ☐ N/A

Affidavit of Good Moral Character: ☐ Yes

Policy & Procedure Manual: ☐ Yes ☐ N/A

Current Organizational Chart: ☐ Yes

Level 2 Background Screening: ☐ Yes

Verification documentation of Qualified Professional(s): ☐ Yes

Treatment Resource Attestation: ☐ Yes

Service Fee Schedule: ☐ Yes

Policies regarding an individual's financial responsibility:

☐ Yes

Policy demonstrating proof of prohibited illicit substances pursuant to s. 397.403, F.S.:

☐ Yes

Provide proof of the availability and provision of meals for the following:

Addictions receiving facilities: ☐ Yes
Day and Night Treatment, If applicable: ☐ Yes

Residential Treatment: ☐ Yes
Day and Night Treatment, If applicable: ☐ Yes

Day or night treatment with community housing: ☐ Yes

Inpatient detoxification: ☐ Yes

Intensive Inpatient treatment: ☐ Yes

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 COMPONENT INFORMATION – Location 1 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

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 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?

☐ Yes ☐ Not Applicable

19. What is the maximum number of clients that can be served in this component on a given day?

20. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (Non-Hispanic)
☐ Other (please describe):

21. List any special population group targeted for services

- ☐ Children
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post-Partum Women
- ☐ Pregnant and Post-Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

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	☐ Subcontract	☐ Other (specify):	
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):	
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):	
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):	
e.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):	

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):

II. PROGRAM COMPONENT INFORMATION – Location 2

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)			2. Telephone (Area Code & Number)	
3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State Florida	7. Zip Code	8. Circuit/Region	9. County
10. Current License Number		11. Current License Expiration Date (MM/DD/YY)		
12. Name of Program Director*		13. Name of Clinical Director*		

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated
    Licensed Bed Capacity:_____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification
  Licensed Bed Capacity:_____
- ☐ Inpatient Methadone Detoxification
  Licensed Bed Capacity:_____
- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment
  Licensed Bed Capacity: _____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity:_____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity:_____

Licensed Bed Capacity:_____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

Location of Housing:_____

Total Bed Capacity:_____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Universal Direct
- ☐ Selective
- ☐ Indicated

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Medication Unit
  Maximum Capacity: _____

15. Hours during which the program is open:

Monday: to ..... ☐ Closed

Tuesday: to ..... ☐ Closed

Wednesday: to ..... ☐ Closed

Thursday: to ..... ☐ Closed

Friday: to ..... ☐ Closed

Saturday: to ..... ☐ Closed

Sunday: to ..... ☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including the expiration date):

Expiration Date

Fire and Safety:..... ☐ Yes .....

Health Standards:

Facility Inspection:.... ☐ Yes ☐ N/A .....

Food Services: ..... ☐ Yes ☐ N/A .....

Zoning Compliance: ..... ☐ Yes .....

Property Insurance:..... ☐ Yes .....

Professional Liability .... ☐ Yes .....
Insurance

Recovery Residence Referral Log: ☐ Yes ☐ N/A

Affidavit of Good Moral Character: ☐ Yes

Policy & Procedure Manual: ☐ Yes ☐ N/A

Current Organizational Chart: ☐ Yes

Level 2 Background Screening: ☐ Yes

Verification documentation of Qualified Professional(s): ☐ Yes

Service Fee Schedule: ☐ Yes

Treatment Resource Attestation: ☐ Yes

Policies regarding an individual's financial responsibility:

☐ Yes ☐ No

Policy demonstrating proof of prohibited illicit substances pursuant to s. 397.403, F.S.:

☐ Yes

Provide proof of the availability and provision of meals for the following:

Addictions receiving facilities: ☐ Yes

Day and Night Treatment, If applicable: ☐ Yes

Residential Treatment: ☐ Yes

Day and Night Treatment, If applicable: ☐ Yes

Day or night treatment with community housing: ☐ Yes

Inpatient detoxification: ☐ Yes

Intensive Inpatient treatment: ☐ Yes

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 COMPONENT INFORMATION – Location 2 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

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 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?

☐ Yes ☐ Not Applicable

19. What is the maximum number of clients that can be served in this component on a given day?

20. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (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
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post-Partum Women
- ☐ Pregnant and Post-Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

22. List the complete names of agencies or practitioners with which you have written referral agreements, contracts, or subcontracts, and check the type of business relationship:

a.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
e.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):

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):

II. PROGRAM COMPONENT INFORMATION – Location 3

1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential Treatment, Outreach Prevention, etc.)	2. Telephone (Area Code & Number)

3. Street Address		4. Building Number, Room Number, Suite, etc.		
5. City	6. State	7. Zip Code	8. Circuit/Region	9. County

10. Current License Number	11. Current License Expiration Date (MM/DD/YY)

12. Name of Program Director*	13. Name of Clinical Director*

14. Type of Service Component **(please check all that apply for this location):**

14a. ***Addictions Receiving Facility:***

- ☐ Please check if you are seeking designation and a license
  - ☐ Addictions Receiving Facility
  - ☐ Juvenile Addictions Receiving Facility
  - ☐ Integrated

  Licensed Bed Capacity:_____

14b. ***Detoxification Programs:***

- ☐ Inpatient Detoxification

  Licensed Bed Capacity:_____
- ☐ Inpatient Methadone Detoxification

  Licensed Bed Capacity:_____
- ☐ Outpatient Detoxification
- ☐ Outpatient Methadone Detoxification

14c. ***Intensive Inpatient Treatment Programs:***

- ☐ Intensive Inpatient Treatment

  Licensed Bed Capacity: _____

14d. ***Residential Programs:***

- ☐ Level 1; Total Bed Capacity:_____
- ☐ Level 2; Total Bed Capacity: _____
- ☐ Level 3; Total Bed Capacity: _____
- ☐ Level 4; Total Bed Capacity:_____

  Licensed Bed Capacity:_____

14e. ***Day or Night Treatment Programs with Community Housing:***

- ☐ Day or Night Treatment Programs with Community Housing

  Location of Housing:_____

  Total Bed Capacity:_____

14f. ***Day or Night Treatment Programs:***

- ☐ Day or Night Treatment

14g. ***Intensive Outpatient Programs:***

- ☐ Intensive Outpatient Treatment

14h. ***Outpatient Programs:***

- ☐ Outpatient Treatment

14i. ***Aftercare Programs:***

- ☐ Aftercare

14j. ***Intervention Programs:***

- ☐ Case Management
- ☐ General Intervention
- ☐ Employee Assistance Program
- ☐ Treatment Alternatives for Safer Communities (TASC)

14k. ***Prevention Programs:***

- ☐ Universal Direct
- ☐ Selective
- ☐ Indicated

14l. ***Medication-Assisted Treatment for Opioid Addiction Programs:***

- ☐ Medication and Methadone Maintenance Treatment
- ☐ Medication Unit

  Maximum Capacity: _____

15. Hours during which the program is open:

Monday: to ..... ☐ Closed

Tuesday: to ..... ☐ Closed

Wednesday: to ..... ☐ Closed

Thursday: to ..... ☐ Closed

Friday: to ..... ☐ Closed

Saturday: to ..... ☐ Closed

Sunday: to ..... ☐ Closed

16. Submit with this application evidence of compliance for applicable areas below (including the expiration date):

Expiration Date

Fire and Safety:..... ☐ Yes .....

Health Standards:

Facility Inspection:.... ☐ Yes ☐ N/A .....

Food Services: ..... ☐ Yes ☐ N/A .....

Zoning Compliance: ..... ☐ Yes .....

Property Insurance:..... ☐ Yes .....

Professional Liability .... ☐ Yes .....
Insurance

Recovery Residence Referral Log:.. ☐ Yes ☐ N/A

Affidavit of Good Moral Character: ☐ Yes

Policy & Procedure Manual: ☐ Yes ☐ N/A

Current Organizational Chart: ☐ Yes

Level 2 Background Screening: ☐ Yes

Verification documentation of Qualified Professional(s): ☐ Yes

Treatment Resource Attestation: ☐ Yes

Service Fee Schedule: ☐ Yes

Policies regarding an individual's financial responsibility:

☐ Yes

Policy demonstrating proof of prohibited illicit substances pursuant to s. 397.403, F.S.:

☐ Yes

Provide proof of the availability and provision of meals for the following:

Addictions receiving facilities: ☐ Yes

Day and Night Treatment, If applicable: ☐ Yes

Residential Treatment: ☐ Yes

Day and Night Treatment, If applicable: ☐ Yes

Day or night treatment with community housing: ☐ Yes

Inpatient detoxification: ☐ Yes

Intensive Inpatient treatment: ☐ Yes

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 COMPONENT INFORMATION – Location 3 (Continued)

17. Medication-Assisted Treatment (i.e., programs which use methadone or other medications for treating opioid addiction). **Submit copies of approval documents with this application.**

- ☐ State Methadone Authority
- ☐ Board of Pharmacy – submit a copy of the pharmacy permit
- ☐ Verification of the services of a consultant pharmacist
- ☐ Not Applicable

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 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?

☐ Yes ☐ Not Applicable

19. What is the maximum number of clients that can be served in this component on a given day?

20. Target Population:

☐ White (Non-Hispanic) ☐ American Indian ☐ Hispanic ☐ Black (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
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ Criminal Justice-Involved Adults
- ☐ Juvenile Justice-Involved Youth
- ☐ Pregnant and Post-Partum Women
- ☐ Pregnant and Post-Partum Adolescents
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults
- ☐ Co-occurring
- ☐ Intravenous Drug Users
- ☐ Other (please describe other group):

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	☐ Subcontract	☐ Other (specify):
b.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
c.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):
d.	☐ Agreement	☐ Contract	☐ Subcontract	☐ Other (specify):

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):