Division of Licensing and Background Checks
Office of Licensing Program/Site Renewal License Application

PLEASE USE A SEPARATE APPLICATION FOR EACH SITE REQUESTED

❖PROGRAM SITE INFORMATION

Site Name – Name to Appear on License

Site Street Address of License

Site City, State, Zip

Site Telephone Number

Site Contact name

Site Email Address

❖PARENT ADMINISTRATIVE PROGRAM
(for programs with more than one licensed site)

Parent Program Name

Administrative Mailing Address (if different from site)

City, State, Zip

Administrative Telephone Number

Administrative Contact Name

Administrative Email Address

Program/Site Website(s) _____

Please list the name of the director to be immediately available at all times that the program is in operation:_____. *When not available, a designee must be assigned and available*

Licensor name: _____

Is this application being submitted in regard to a relocation of a currently licensed program?

☐ Yes ☐ No ***note**: for adding a new site or category to a licensed program, use Initial Application form*
If yes, list previous site name and address:_____

Is this application being submitted in regard to a request for changed capacity? ☐ Yes ☐ No
If yes, please submit a floor plan outlining designated space and measurements for capacity determination.

Have there been any changes to site, program or parent program names over the past year?

☐ Yes ☐ No If yes, please list: _____

❖ LICENSE CATEGORY AND FEES (follow links to see applicable rules and definitions).

❖ CLIENTS SERVED AT THIS SITE

Total Licensed Capacity #: _____ # Clients Currently Enrolled: _____

☐Youth (under age 18) ☐Adults ☐Male ☐ Female

☐	Adult Day Care (50 or fewer)	$300 +$9.00 per licensed capacity*
☐	Adult Day Care (51 or more)	$600+$9.00 per licensed capacity*
☐	Residential Treatment	$600+$9.00 per licensed capacity*
☐	Intermediate Secure Care	$750+$9.00 per licensed capacity*
☐	Therapeutic School	$600+$9.00 per licensed capacity*

License Fees: $ _____ **+ Capacity (*):** _____ **x $9.00 = Total $** _____

☐	Outpatient Treatment	$300	☐	Child Placing Adoption	$750
☐	Child Placing Foster	$250	☐	Day Treatment	$450
☐	Social Detoxification	$600	☐	Outdoor Youth	$1,408
☐	Recovery Residence	$500	☐	Residential Support	$300

License Fees: $ _____ **Total $** _____

Only cashier's checks, money orders or company checks made payable to DHHS Office of Licensing will be accepted. Please **no cash or personal checks**. We hope to be able to accept online payments in the future.

In addition to categorical rules, all licensees are required to also adhere to: General Provisions **(R-501-1)and** Background Screening rules **(R-501-14).** All Licensing rules may be accessed via the links on this page or https://rules.utah.gov/publicat/code/r501/r501.htm

❖ SPECIALIZED SERVICES REQUESTED

☐None
☐Substance Use Disorder
☐Medication-Assisted Substance Use Disorder Treatment
☐Mental Health
☐Domestic Violence Treatment
☐Domestic Violence Shelter
☐Temporary Youth Homeless Shelter
☐Youth Residential (Congregate Care)
☐Other_____

Are any of these requested services different from the previously licensed services? ☐ Yes ☐ No

If yes, please explain: _____

_____

If this site has sustained any changes that differ from the previous application information submitted and approved by the office of Licensing, they must be disclosed. Please address all changes in each of the following sections:

❖ PROGRAM AFFILIATIONS

Accreditation changes:

☐No Accreditation ☐No Accreditation Changes ☐Add or Change Accreditation

Organization Name:_____Contact name: _____ Contact phone:_____Contact email:_____ ☐Remove Accreditation status:

Reason:_____

Division of Substance Abuse and Mental Health Certification status: ☐ None

☐Remove previous DSAMH Certifications ☐Add New or Change Previous Certification

Please check all that apply to current status: ☐DUI Education ☐Justice Reinvestment Initiative (JRI)

Department of Health and Human Services Contract status: ☐ None

☐Remove Previous Contract Status: Reason: _____

☐Add New or Change Previous Contract Status

Please check all Divisions with whom you hold a contract: ☐ Division of Child and Family Services

☐Division of Juvenile Justice Services ☐Division of Services for People with Disabilities

☐other:_____

Does this site serve clients on a DSPD Home Community Based Services (HCBS) waiver? ☐Yes ☐ No

If yes, please attach applicable Attestation Form (Residential or Non-Residential) found on the DOH website here: https://medicaid.utah.gov/ltc/hcbstransition/

❖ PROGRAM GOVERNANCE

Has there been a change in owner(s), director(s) as defined in R501-1 or any individuals ultimately responsible for operations and business decisions of this site since the previous license was issued? ☐ Yes ☐ No If yes, please explain and provide each new Name, Home Address, Home Phone # and Personal email address***note:** personal information is private and used only for OL to contact responsible parties in the event of a closure or interruption in services*:

_____

_____

_____

_____

_____

_____

☐ If there are more individuals to be listed, please check this box and provide an additional page as an attachment.

Have there been any changes to any aspect of the program or policies and procedures over the past year? ☐ Yes ☐ No If yes, please briefly explain and attach copies highlighting/outlining the changes.

_____

❖ REQUIRED DISCLOSURES

Please list any potential conflicts of interest that may exist in the relationships and services provided or referred to by individuals associated with this site. Please attach a plan to mitigate these conflicts.

Has this program (or any associated individuals) applied for and been **denied** DHS licensure within the 3 months prior to the date of this application? ☐ Yes ☐ No If yes, please explain:

Have any of the individuals associated with this program been an associate of a program that has had its license **revoked** within the past 5 years? ☐ Yes ☐ No If yes, please explain with names, dates and circumstances: _____

☐ If additional pages are necessary for this section, please check this box and provide as attachments.

Does this program prescribe, store, administer, distribute or dispense controlled substances? ☐Yes ☐No
If yes, please list the following for all prescribing licensed practitioners:
Name:_____ DOPL #:_____ DEA #:_____
Name:_____ DOPL #:_____ DEA #:_____
☐ If there are more individuals to be listed, please check this box and provide as attachment.
DEA Registration Number for this site:_____

☐ Have there been any Office of Licensing variances or exemptions offered at this site over the course of the previous licensing year? ☐ Yes ☐ No If yes, are they being sought for continuance? ☐ Yes ☐ No If yes, please provide a justification statement with this application per 501-1-8.7.

❖ REQUIRED DOCUMENTATION

Please submit this renewal application to the DLBC, Office of Licensing at least **30 days prior** to your expiration date. The following checklist items will also be required for renewal. Please submit as many of these required documents as possible with this application (or email them to your licensor). Any missing documents will need to be submitted prior to your expiration date to avoid lapse in licensure. All Health and Human Services Rules governing licensed facilities may be accessed on the DLBC website: hhttps://dlbc.utah.gov/home/office-of-licensing/human-services/license-types-and-rules.

*Please submit documentation regarding any administrative changes made since previous licensure: (ie: organizational structure, populations served, services offered, fee changes, billing practices, job descriptions etc). For any previous approved or consulted policies, please complete the policy and procedure consultation/approval request template with only the changes since the Office's last review.

Date of last Policy review:_____

☐ Non-Descrimination Policy _____ _

☐ Congregate Care Behavior Management/Restraint/Seclusion/Prohibited Practices _____ __

☐ Congregate Care Suicide Prevention Policy _____ ___

Have any of the policies and procedures been amended since they were reviewed or approved by DLBC?

☐ Yes ☐ No

If yes for any, please submit a policy and procedure consultation/approval request template containing items requiring review

*Please attach copies of all categorically appropriate clearances (or documentation showing exemption) to include fire clearance, health department clearance (for facilities with kitchens or serving food) and business license.

*Please attach proof of current insurance policies to include: general liability, fire, vehicle (if transporting clients) and professional liability insurance.

*Please provide copies of current OHHS contracts, certifications and accreditations held at this site.

*Please submit any attachments needed to expand the information listed in the "Governance" and "Disclosures" sections of this application.

*Please submit a justification statement for continuance of any Office of Licensing issued variances or exemptions.

For capacity change request for Day Treatment, Residential Treatment, Recovery Residence, Adult Daycare, Therapeutic Schools and Intermediate Secure Care categories please attach a floorplan with measurements and new local clearances as required. *Note: licensed capacity must be congruent with fire inspection and business license determinations to include all staff and visitors when there is a maximum capacity noted. Client capacity will be the sole capacity determinant when the business license/fire clearance clearly designate as such*

❖ RENEWAL PREPARATION

*Please complete and place comments in the applicable DBLC, OL checklists (General Provisions/ Categorical). It is strongly recommended that this be done repeatedly throughout the licensing year to assist in maintaining ongoing compliance and providing the highest quality of care and services to the clients served. By thoroughly reviewing and completing these checklists prior to license renewal, you will be able to prepare your facility and practices and expedite the issuance of your renewal license.

Note: Utah statute 62A-2-108(4) indicates that a license that is not in compliance with licensing rules at the time of expiration cannot be renewed. If you anticipate difficulty in meeting compliance with OL rules at the time of your expiration, please contact your licensor well in advance to address concerns together.

BACKGROUND SCREENING INFORMATION

List CBS/DACS screening agents:

Name_____Email_____

Name_____Email_____

Do you currently hold approval for background clearance exemptions for your agency? Y N
Have any changes been made to services offered to require review of this exemption? Y N
Please explain:

_____
_____
_____
_____

Do you currently hold approval for automatic denial exemption for your agency? Y N
Have any changes been made to services offered to require review of this exemption? Y N
Please explain.

_____
_____
_____
_____

Full Clearance Exemption: 62A-2-120-13 indicates:
An individual or a department contractor who provides services in an adult-only substance use disorder program, as defined by rule, is exempt from this (background clearance requirements) section. **This exemption does not extend to a program director or a member, as defined by Section 62A-2-108, of the program.**

Automatic Denial Exemption: 62A-2-120 S(c) indicates:

If the applicant will be working in a program serving only adults whose only impairment is a mental health diagnosis, including that of a serious mental health disorder, with or without co-occurring substance use disorder, the denial provisions of Subsection (S)(a) do not apply, and the office shall conduct a comprehensive review as described in Subsection (6).

PLEASE NOTE THAT APPLICANTS MAY NOT PROVIDE ANY DIRECT ACCESS TO CLIENTS OR CLIENT IDENTIFYING INFORMATION UNTIL ALL INDIVIDUALS WITH SUCH ACCESS HAVE CLEARANCES APPROVED BY THE DLBC, OFFICE OF BACKGROUND PROCESSING

❖ DECLARATIONS

I declare the following:

- **I am an authorized representative of this program.**
- **I have reviewed and understand the Licensing rules applicable to this site.**
- **The information provided within this application is thorough, accurate and true.**
- **I have thoroughly identified all individuals responsible for this site.**
- **I understand that this application may be denied (or a penalty assessed, once licensed) for providing misleading or false information to the DLBC, Office of Licensing, program clients, prospective clients or the public.**

Name of individual completing this application: _____
Title:_____ Date:_____

(Electronically filling in or signing and submitting this application constitutes acknowledgment of thorough and truthful application information disclosure).

Please submit no less than 30 days prior to expiration.

Please submit this form and accompanying documentation and fees to:

DHHS
Division of Licensing and Background Checks
Office of Licensing
195 North 1950 West, Salt Lake City, UT 84116
Main Office: **801-538-4242** Fax: **801-538-4553**

❖ FOR OFFICE USE ONLY ❖

Initials of process specialist: _____ Fees are: ☐Accepted ☐Returned
if returned: Reason:_____ Date: _____
Action requested:_____

_____	_____	_____	_____
Date fee accepted	Amount submitted	Check number	Check date

☐Application Accepted

☐ Application Denied via NAA. Reason: _____