





No  Yes: If yes, indicate the program, date, and reason(s) for denial, suspension, and/or revocation:

The program is applying for Deemed Status under:

CARF  JCAHO  Other (Specify)

**Complete Attachment C for Deemed Status**

**V. GEORGRAPHIC AREA(S) SERVED BY THE PROGRAM**

(PLEASE IDENTIFY THE GEOGRAPHIC AREA BY STATE, COUNTY, CITY, MUNICIPALITY ETC...AS APPROPRIATE)

\_\_\_\_\_ State(s) \_\_\_\_\_ County(ies)

\_\_\_\_\_ City(ies) \_\_\_\_\_ Other

**FOR INITIAL APPLICANTS:** Explain the process you used (e.g. Needs Assessment) to substantiate a need for this type of program, at this time, in this particular geographic area. Attach any documentation that substantiates your explanation. **Re-licensure request move onto section VI.**

**VI. HOURS OF OPERATION**

SUNDAY \_\_\_\_\_

MONDAY \_\_\_\_\_

TUESDAY \_\_\_\_\_

WEDNESDAY \_\_\_\_\_

THURSDAY \_\_\_\_\_

FRIDAY \_\_\_\_\_

SATURDAY \_\_\_\_\_

**VII. FUNDING SOURCES (Please note that licensure does NOT constitute a contract or entitle a program to funding from the Division of Substance Abuse and Mental Health.)**

Dollar Amount (in thousands)

Source Description

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**VII FUNDING SOURCES CONTINUED...**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**VIII POPULATION**

PLEASE PROVIDE CLIENT DEMOGRAPHIC INFORMATION

Children and Youth (17 and under)

Adults (18 and over)

Male  Female

List the average number of clients involved (actual/projected) in the program per month by primary diagnosis.

	<u>Actual</u>	<u>Projected</u>
Primary Alcohol or Drug	_____	_____
Polysubstance Abuse	_____	_____
Co-occurring (AOD/MH)	_____	_____

1. Indicate the average length of stay for clients in the program (actual or projected.) Give answers in days if less than 1 month, otherwise give answer in months.

Actual

Projected

\_\_\_\_\_

\_\_\_\_\_

2. Indicate the actual/projected staff to client ratio:\_\_\_\_\_

a. Complete Attachment **A Personnel**

3. Indicate the actual number of members of the organizations Governing Body.

a. Complete Attachment B **Governing Body.**

4. If you have or are projecting a waiting list please indicate the number of individuals and the average waiting period preceding admission:

1. Number of clients on waiting list:

Actual \_\_\_\_\_ Projected \_\_\_\_\_

2. Average waiting period preceding admission:

Actual \_\_\_\_\_ Projected \_\_\_\_\_

**I hereby confirm that the program for which I am applying for licensure conforms to the Delaware Division of Substance Abuse and Mental Health Substance Abuse Facility Licensing Standards; Del 16 §6000.**

\_\_\_\_\_  
President of Governing Body/Advisory Council

\_\_\_\_\_  
Program Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date









**GOVERNING BODY (CONTINUED)**

1. Please list all Governing Body members who are related to staff members of the program and explain the relationship.

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2. Please explain how the Governing Body is representative of the community it serves.

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