

**DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
APPLICATION FOR LICENSURE - INSTRUCTIONS FOR
ALCOHOLISM AND/OR DRUG ABUSE PROGRAMS**

1. DSAMH Licensure Standards should be carefully reviewed. Programs shall comply with all applicable portions of Sections 5 through 14, unless otherwise waived.

2. FOR INITIAL APPLICANTS ONLY:

After reviewing the DSAMH Standards, each standard should be self-rated according to the following scale:

1. Program is in full compliance with this standard.
2. Program is not in compliance. Could be in compliance within 180 days.
(Next to the standard indicate briefly the steps you will take to bring your program into full compliance with this standard.)
3. Program is not in compliance. Would need longer than 180 days to bring into full compliance.
4. Program is applying for a waiver of this standard.
5. This standard does not apply to this program since it refers to a service not provided by the program.

Be sure to rate all applicable portions of each Standard.

3. When completing the application, the following points should be noted:

- **PROGRAM NAME:** The full official title of the program must be used.

- **ADDRESS:** The full address of the program's headquarters. If the program uses more than one facility, provide addresses for all facilities used on a supplemental sheet.
- **TELEPHONE:** The telephone number of the program's headquarters. If the program has more than one facility, provide telephone numbers of all facilities on a supplemental sheet.
- **Under II(B) PROGRAM MANAGEMENT,** "Race" is asked to ensure that as per Standard 5.1.1.: "The governing body or advisory groups shall be representative of the community."

4. ANY QUESTIONS CONCERNING LICENSURE SHOULD BE

DIRECTED TO THE LICENSING OFFICE @ 255-9441, 255-9442,

255-9443 or 302/424-2947

**STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
1901 N. DuPont Highway
New Castle, DE 19720**

APPLICATION FOR LICENSURE

DATE OF APPLICATION: _____

Check one: INITIAL APPLICATION RENEWAL APPLICATION

I. PROGRAM IDENTIFICATION

A. Name: _____

B. Address: _____

C. Telephone: Area Code: _____ Number: _____

D. Type of Program Licensure for which application is being made.

Check the appropriate box or boxes

Detoxification

Alcohol Program

Residential Setting

Drug Program

Outpatient Setting

Alcohol & Drug Program

Prevention

Private

Public

Profit

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- Non-profit
- Emergency Telephone Service
- DUI Outpatient Treatment Setting
- DUI Education Setting
- Evaluation/Screening Setting
- Other (specify)

E. Geographical area(s) served by program: _____

F. Days and Hours of Operation: _____

G. Funding sources:

<u>Dollar Amount (in thousands)</u>	<u>Source Description</u>
_____	_____
_____	_____
_____	_____
_____	_____

H. Is the program currently licensed, certified, or accredited by any local, state, federal, or private body?

- No
- Yes: If yes, indicate which type: LICENSURE
- CERTIFICATION ACCREDITATION, from
- what agency: _____, and date of expiration: _____.

I. Has the program ever had a license denied, suspended, and/or revoked?

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

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II. PROGRAM MANGEMENT

A. Name of Director: _____

Address: _____

Title: _____

B. GOVERNING BOARD OR ADVISORY COUNCIL: On Form A of this application indicate the name, address, occupation, relation to staff and race of your Governing Board and/or Advisory Council. Attach additional sheets if necessary.

NOTE: If the program has both a Governing Board and an Advisory Council complete two lists using Form A, checking off the appropriate box to indicate which is the Governing Board and which is the Advisory Council.

III. PROGRAM PERSONNEL

Please indicate on Forms B and C the number of program personnel in each occupational category. Indicate whether they are full or part-time employees, volunteers or consultants. Full - time is defined as working more than 30 hours per week. Volunteer services should be expressed in terms of **hours per week**. Consultant's time should be expressed in terms of **hours per month**.

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IV. INFORMATION ON CURRENT OF PROJECTED CLIENT POPULATION

A. CLIENT DEMOGRAPHIC INFORMATION

1. Age: (Check one or more as applicable)

Children and Youth (17 and under)

Adults (18 and over)

2. Sex: (Check on or more as applicable)

Male Female

B. CLIENT STATISTICAL INFORMATION

1. List the average number of clients involved (actual/projected) in the program per month by primary substance of abuse at admission

	<u>Actual</u>	<u>Projected</u>
Primary Alcohol	_____	_____
Primary Drug	_____	_____
Polysubstance Abuse	_____	_____

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

	<u>Actual</u>	<u>Projected</u>
Primary Alcohol	_____	_____
Primary Drug	_____	_____
Polysubstance Abuse	_____	_____

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3. Indicate the actual/projected staff to client ratio: _____

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

Number of clients on waiting list:

Actual _____ Projected _____

Average waiting period preceding admission:

Actual _____ Projected _____

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- V. All of the following information shall be available for review on site at the time of the visit. "R" applies to special instructions for programs seeking relicensure**
- A. Annual program goals and objectives. (R - Updated goals and objectives shall include action steps, time frames, and staff responsible for achieving the action steps.)
 - B. Program services to be provided. (R - only if there are any changes.)
 - C. Manual of policies and procedures in administrative, financial, personnel and program services management. (R - only those policies and procedures which have been updated.)
 - D. Program organization chart. (R - only if it has changed.)
 - E. Samples of any forms used by program and instructions to these forms. (R - only if new ones have been added, or if old ones have been revised.)
 - F. Sample client chart. (R - only if the format for the file has been changed.)
 - G. Copies of any evaluation reports that may exist in reference to the program. (R - any done since the last licensure visit.)
 - H. Corporate and/or Advisory Board By-Laws. (R - only if they have been revised or amended.)
 - I. Staff and Board meeting minutes for the six months prior to the submission of this application.
 - J. Documentation of any current insurance coverage, i.e., fire, program and counselor liability, etc.
 - K. Most recent audit report to include sources of funding.

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L. Most recent annual Program Director's report to the Board of Directors including program and fiscal aspects.

M. The completed self-rated Licensure Standards which apply to your program. (R - only if the program is asking for licensure of a part of the program not in existence at the time of the first license, i.e., if an outpatient program adds a prevention component, or if a residential program adds an outpatient component, etc.)

N. Requests for waivers on standards. (R - only if a new area or areas are being requested.)

President of Governing Body/Advisory Council

Date

Program Director

Date

DSAMH LICENSURE APPLICATION - FORM A

GOVERNING BOARD AND/OR ADVISORY COUNCIL

GOVERNING BOARD

ADVISORY COUCIL

NOTE: Indicate any relationship between a Board member and a Staff member. Attach additional sheets, if necessary.

NAME	ADDRESS	OCCUPATION	RELATION TO STAFF	RACE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

DSAMH LICENSURE APPLICATION - FORM B

I. Direct Service Staff (bachelor's degree and above)

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

II. Direct Service Staff (Less than bachelor's degree)

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

IV. All other Program Staff - (e.g. clerical, maintenance, cooks, etc.)

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

DSAMH LICENSURE APPLICATION - FORM C

III. Administrative Staff - (Staff who devoted 75% or more of their time to administrative as opposed to direct treatment service)

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

IV. All other Program Staff - (e.g. clerical, maintenance, cooks, etc.)

<u>Name</u>	<u>Title</u>	<u>Degree and/or Certification</u>	<u>Yrs. Of Experience Related to the Position</u>	<u>Full-Time</u>	<u>Part-Time</u>	<u>Volunteer</u>	<u>Consultant</u>
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							