STATE OF CONNECTICUT

DEPARTMENT OF CHILDREN & FAMILIES (DCF)
DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
DEPARTMENT OF PUBLIC HEALTH (DPH)

LICENSURE APPLICATION FOR COMMUNITY BASED ENTITY

Application is hereby made for a license to operate a Community Based Entity (please check the appropriate box/box(s) that apply):

DPH

- ☐ Private Freestanding Mental Health Day Treatment Facilities Connecticut General Statutes Section 19a-491 and/or 19a-506
- ☐ Private Freestanding Mental Health Community Residence Connecticut General Statutes Section 19a-491 and/or 19a-506
- ☐ Private Freestanding Mental Health Residential Living Centers Connecticut General Statutes Section 19a-491 and/or 19a-506
- ☐ Private Freestanding Facilities for the Care or Treatment of Substance Abuse or Dependence Connecticut General Statutes Section 19a-491 and/or 19a-506
- ☐ Private Freestanding Psychiatric Outpatient Clinics for Adults Connecticut General Statutes Section 19a 491 and or 19a-506

DCF

- ☐ Extended Day Treatment Connecticut General Statutes Section 17a-147
- ☐ Out-Patient Psychiatric Clinic for Children Connecticut General Statutes Section 17a-20

- ☐ Residential Treatment Connecticut General Statutes Sections 17a-145 & 17a-151
- ☐ Residential Education Connecticut General Statutes Section 17a-145
- ☐ Group Home Connecticut General Statutes Sections 17a-145 & 17a-151
- ☐ Temporary Shelter Connecticut General Statutes Sections 17a-145 & 17a-151
- ☐ Child Placing Agency Connecticut General Statutes Section 17a-150

DDS

- ☐ Community Living Arrangement for persons with intellectual disability and/or person with autism spectrum disorder Connecticut General Statutes Section 17a-227

THIS APPLICATION WILL BE PROCESSED FOR (check one choice from below)

- ☐ Initial Application
- ☐ Adding an Additional Site
- ☐ Change in Capacity
- ☐ Relocation of facility (DPH)
- ☐ Change in age range (DCF)
- ☐ Change of Licensee or D/B/A name
- ☐ Renewal Application
- ☐ Change in Location (DCF)
- ☐ Removing a location/Site
- ☐ Relocation of Parent Site
- ☐ Change of Ownership
- ☐ Change of Services (DPH)

Phone: (860) 509-7444 for DPH
(860) 550-6532 for DCF
(860) 418-6081 for DDS
Telephone Device for the Hearing Impaired (860) 509-7191
An Equal Opportunity Employer

EMERGENCY INFORMATION (Facility After Hours):
For the Executive Director and his/her Backup

1. Business Email address : Business Fax #:

2. Business cell phone # with texting capabilities: (Executive Director)

3. Business cell phone # with texting capabilities: (Back up)

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1. License #: (DDS)

2. RDID #: (DDS)
Residence or Day ID# for Renewals or Capacity Changes

3. Facility or Agency "d/b/a" (doing business as) Name; (for DPH) (name of the residence, DDS)

Facility Address
City
State Zip Code Telephone

Mailing Address (if applicable)
City
State Zip Code

4. Capacity type requested **(if applicable).** If submitting this application for multiple levels of care, please list the bed capacity (if any) for each level of care being requested. (DCF please include age/gender). (For DPH & DDS, please include the capacity/type only)

CAPACITY/TYPE	AGE	GENDER

5. Disclose the legal entity which owns/operates the facility. (Note: The license will be issued to this entity.-DPH); (Corporate name of the applicant for DCF or DDS)

Licensee (DPH) Corporate Name (DCF & DDS)

Business Address
City State Zip Code Telephone

Mailing Address (if applicable)

6. If the residence or program is run by a management company, please list the following information: (DDS)
   Management Company Name

   Business Address
   City State Zip Code Telephone

   Mailing Address (if applicable)

7. SUBSTANCE ABUSE FACILITIES ONLY, please check applicable services/beds (DPH):

☐ Intensive Treatment Beds ____ ☐ Medical Triage Beds _____

☐ Care and Rehabilitation Beds _____

☐ Intermediate & Long Term Treatment & Rehab. Beds _____

☐ Residential Detoxification & Evaluation Beds _____

☐ Ambulatory Chemical Detoxification Treatment ☐ Day or Evening Treatment

☐ Chemical Maintenance Treatment ☐ Outpatient Treatment

8. CHANGE OF LICENSE

If requesting a change to your current license, briefly describe in this box (DCF)

9. Affidavit of Applicant (as required by law):
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

_____ _____

Signature of the Administrator (DCF/DDS) Date Signed
President/Secretary of Corporation (DPH)
Municipal Officer (DPH)
LLC Member (DPH)
Individual/Sole Proprietor (DPH)

_____ _____

Signature of Board Chair (DCF) Date Signed

State of Connecticut)

County of _____) ss _____ 20_____

Personally appeared before me the above named _____ and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

_____

☐ Notary Public
☐ Justice of the Peace
☐ Town Clerk
☐ Commissioner of the Superior Court

My Commission Expires:
(If Notary Public)