

**Missouri Department of Mental Health
Office of Licensure & Certification**

APPLICATION FOR LICENSURE - INSTRUCTIONS

- **Please complete and return all applications promptly.**
- All applications must be complete. **If information is missing, the application will be returned to you requesting inclusion of the missing information.** If a section is not applicable to your agency/facility, please note that with an N/A in those sections.
- Print clearly and legibly using black ink or type; please do not use pencil.
- If you want to request more than one facility or program to be licensed, there is space on Page 2 of the application to list the additional facilities or programs.
- Clearly check all the programs or services applicable to your licensure on Page 2 of the application.
- For **initial** applications:
 - Submit a floor plan of the facility with a narrative of how each room is to be used.
 - Include your staffing pattern, indicating the number of direct care staff on duty during each shift Monday through Sunday.
- If you are requesting **renewal** of your annual license:
 - If you are *remodeling* or *changing the structure* and use of your building, include a floor plan of the facility with a narrative indicating how each room is to be used.
 - It is not necessary to submit your staffing pattern, unless it has changed within the last licensure cycle.
- **Fees:** Enclose the following license fee for each facility/agency to be licensed under this application.
 - For facilities/agencies with three (3) or fewer residents/participants, no fee.
 - For facilities/agencies having at least four (4), but fewer than 10 residents/participants--\$10.00.
 - For facilities/agencies having 10 or more residents/participants--\$50.00.
 - For facilities that are licensed by the Department of Health and Senior Services (DHSS), the Department of Mental Health (DMH) licensure fee is based upon the licensed capacity determined by DHSS, not the number of DMH clients residing in the facility.
- **Mail your completed application packet that includes the NOTARIZED application and correct licensure fee to:**

**Missouri Department of Mental Health
Licensure and Certification Unit
PO Box 687
Jefferson City, MO 65101**

➤ **Business Registration**

- Make sure you complete the section regarding Business Registration with the Secretary of State.

➤ **Fire/Safety Inspections:**

- All *residential programs*, except those dually licensed by the DHSS and DMH, must have an approved fire inspection from the State Fire Marshal. This includes group homes for the mentally ill and/or developmentally disabled, family living arrangements and semi-independent living arrangements.
- All *day programs* serving the mentally ill and/or developmentally disabled must have an approved fire inspection from the State Fire Marshal.
- **Upon receipt** of your completed NOTARIZED application and fee, if a request for fire/safety inspection is required, the Licensure and Certification Office will complete the request.

NOTE: Obtaining a DMH license *does not* guarantee funding or placement of consumers by DMH.

If you have questions regarding your application, please contact:

Judy Scheulen
Licensure and Certification Unit
Department of Mental Health
573-751-4024



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
 1706 E. ELM STREET, P.O. BOX 687
 JEFFERSON CITY, MISSOURI 65102
APPLICATION FOR LICENSURE

DMH USE ONLY	
FEE RECEIPT #	INITIAL/RENEWAL/LCRO
FEE AMOUNT	EXPIRATION DATE
IDENTIFIER	

NAME OF FACILITY/PROGRAM		TELEPHONE NUMBER		FAX NUMBER	
FOR PROFIT <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Privately Owned <input type="checkbox"/> Other (specify) _____		NOT FOR PROFIT <input type="checkbox"/> Corporation <input type="checkbox"/> Charitable <input type="checkbox"/> Church Affiliate <input type="checkbox"/> Other (specify) _____		GOVERNMENT <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> District <input type="checkbox"/> State <input type="checkbox"/> Veteran Administration <input type="checkbox"/> Other (specify) _____	
NAME OF DIRECTOR OR FOSTER PARENT		TITLE		EMPLOYER TAX ID NO. OR SOCIAL SECURITY NO.	
ADDRESS OF AGENCY/FACILITY		CITY		STATE	
BILLING/MAILING ADDRESS		CITY		STATE	
CONTACT PERSON OF FACILITY/AGENCY		TELEPHONE NUMBER		TITLE	
E-MAIL ADDRESS		WEB SITE			
GOVERNING BODY PRESIDENT		ADDRESS		CITY	
				STATE	
				ZIP CODE	
NAME OF CORPORATE OWNER, IF APPLICABLE					
ADDRESS OF CORPORATE OWNER		CITY		STATE	
				ZIP CODE	
BUSINESS REGISTRATION: ARE YOU REQUIRED TO BE REGISTERED WITH THE SECRETARY OF STATE?				CHARTER #	
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT IS YOUR CHARTER # AND EXPIRATION DATE?				EXPIRATION DATE	
FIRE SAFETY: IS THE RESIDENTIAL OR DAY PROGRAM SITE(S) SERVED BY A VOLUNTEER FIRE ASSOCIATION OR SUBSCRIPTION FIRE DEPARTMENT?					
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ATTACH DOCUMENTATION OF CURRENT CONTRACT OR PROOF OF MEMBERSHIP FOR EACH SITE.					
OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)		FACILITY/PROGRAM TYPE		EFFECTIVE DATE	
HAS ANY PERSON NAMED ON THIS APPLICATION BEEN CONVICTED OF A FELONY?					
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE SUBMIT EXPLANATION ON A SEPARATE PAGE.					

ARE YOU REQUESTING LICENSURE FOR ADDITIONAL FACILITIES OR PROGRAMS UNDER THIS APPLICATION

YES NO IF SO, PLEASE LIST BELOW:

NAME OF FACILITY/PROGRAM		TELEPHONE NUMBER		FAX NUMBER	
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ADDRESS		CITY		STATE	ZIP CODE	COUNTY
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E-MAIL ADDRESS	WEB PAGE		NAME & TITLE OF CONTACT PERSON		
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OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)		FACILITY/PROGRAM TYPE		EFFECTIVE DATE	EXPIRATION DATE

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E-MAIL ADDRESS	WEB PAGE		NAME & TITLE OF CONTACT PERSON		
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OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)		FACILITY/PROGRAM TYPE		EFFECTIVE DATE	EXPIRATION DATE

ARE THERE ANY PORTIONS/COMPONENTS/PROGRAMS OF YOUR AGENCY FOR WHICH YOU ARE NOT REQUESTING LICENSURE?
 YES NO IF YES, PLEASE EXPLAIN WHY:

IS THE FACT THAT NOT ALL COMPONENTS OF YOUR AGENCY ARE LICENSED, MADE CLEAR TO INDIVIDUALS RECEIVING THOSE SERVICES?
 YES NO HOW IS THIS DONE? _____ (PLEASE SUBMIT A COPY OF YOUR AGENCY'S BROCHURE FOR

CHECK ALL PROGRAMS FOR WHICH APPLICATION IS BEING MADE AND INDICATE CAPACITY WHERE NOTED.

<input type="checkbox"/> Family Living Arrangement/Treatment Family Home (MI/MD) – Capacity _____	<input type="checkbox"/> ICF – Capacity _____
<input type="checkbox"/> Family Living Arrangement (DD) – Capacity _____	<input type="checkbox"/> Group Home (MI) – Capacity _____
<input type="checkbox"/> RCF – Capacity _____	<input type="checkbox"/> Group Home (DD) – Capacity _____
<input type="checkbox"/> SNF – Capacity _____	<input type="checkbox"/> Semi-Independent Living Arrangement – Capacity _____
<input type="checkbox"/> ICF/ID – Capacity _____	<input type="checkbox"/> Day Program (MI) – Capacity _____
	<input type="checkbox"/> Day Program (DD) – Capacity _____

ACKNOWLEDGEMENT

MISSOURI

CITY OF _____

COUNTY OF _____

GOVERNING BODY PRESIDENT

and

CHIEF ADMINISTRATIVE OFFICER

being duly sworn to me on his/her oath, deposes and says that he/she has read the foregoing application and that the statements contained therein are true and correct to the best of his/her knowledge; and further gives assurance of the ability and intention of

NAME OF APPLICANT OR AGENCY

to comply with the laws applicable to licensed and certified facilities and the regulations

established thereunder. It is understood that _____

NAME OF APPLICANT OR AGENCY

will be eligible for licensure or certification only after it has complied with the requirements of the law and the regulations and codes, and that such licensure or certification is subject to revocation at any time this agency fails to comply with the law, regulations and codes.

Furthermore, it is agreed that agents of the Department of Mental Health are authorized by law to make inspections of the premises, talk to employees, residents or clients about the operation of the facility, and to audit the financial records of this agency.

GOVERNING BODY PRESIDENT

and

CHIEF ADMINISTRATIVE OFFICER

further certify that he/she will comply with

all requirements, corrections and/or improvements in _____

NAME OF APPLICANT OR AGENCY

contained in the survey reports completed by the authorities of the Department of Mental Health and submitted to said program.

SIGNATURE (PRESIDENT)

SIGNATURE (CHIEF ADMINISTRATIVE OFFICER)

NOTARY INFORMATION

NOTARY PUBLIC EMBOSSER OR
BLACK INK RUBBER STAMP SEAL

STATE

COUNTY (OR CITY OF ST. LOUIS)

SUBSCRIBED AND SWORN BEFORE ME, THIS

USE RUBBER STAMP IN CLEAR AREA BELOW.

DAY OF

YEAR

NOTARY PUBLIC SIGNATURE

MY COMMISSION
EXPIRES

NOTARY PUBLIC NAME (TYPED OR PRINTED)