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FEE RECEIPT #	FEE AMOUNT
IDENTIFIER	

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
1706 EAST ELM STREET, P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
FAX: (573) 751-7815

APPLICATION FOR LICENSURE

Before we can accept your application for processing, it must be complete. **The application will be returned to you requesting inclusion of any 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 in black ink or type.

Please return the application and any necessary documentation at least 90 days prior to the expiration date of your license.

PROVIDER INFORMATION

LEGAL NAME OF FACILITY	FEDERAL TAX ID OR SOCIAL SECURITY NUMBER	
	SOS CHARTER NO.	EXPIRATION DATE
FACILITY PHYSICAL STREET ADDRESS		COUNTY FACILITY LOCATED IN
CITY	STATE	ZIP CODE
FACILITY E-MAIL ADDRESS	TELEPHONE NUMBER	FAX NUMBER
FACILITY MAILING ADDRESS		
CITY	STATE	ZIP CODE
PRIMARY CONTACT PERSON	TITLE	
CONTACT EMAIL ADDRESS	CONTACT PHONE NO.	CONTACT FAX NO.
NAME OF CORPORATE OWNER (IF DIFFERENT THAN NAME OF FACILITY)		
ADDRESS OF CORPORATE HOME OFFICE	CITY	STATE / ZIP

TYPE OF OPERATOR (CHECK ONE)

☐ Sole Proprietorship ☐ Limited Liability Company (LLC) ☐ Limited Liability Partnership
☐ General Business Corporation ☐ Nonprofit Corporation ☐ Other (Specify)_____
☐ General Partnership ☐ Limited Partnership

HAS ANY PERSON NAMED ON THIS APPLICATION OR ANYONE PART OF THE PROVIDER AGENCY BEEN FOUND GUILTY OF OR PLEAD GUILTY TO OR NOLO CONTENDERE TO ANY DISQUALIFYING CRIME, AS OUTLINED IN SECTION 630.170, RSMO?

☐ Yes ☐ No If yes, please submit explanation and copy of DMH exception approval.

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

☐ Family Living Arrangement/Treatment Family Home (MI/MD) Capacity_____	☐ Group Home (DD) Capacity_____
☐ Family Living Arrangement (DD) Capacity_____	☐ Psychiatric Group Home Capacity_____
☐ RCF – Capacity_____ ☐ SNF – Capacity_____ ☐ ICF – Capacity_____	☐ Day Program (MI) Capacity_____
☐ ICF/IID Capacity_____	☐ Day Program (DD) Capacity_____

OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH)

Please submit a copy of the agency's current license, certificate or accreditation report with this application. (Dept. of Health & Senior Services, Dept. of Social Services, Dept. of Elementary & Secondary Education, CARF, etc.)

NAME OF ORGANIZATION	PROGRAM TYPE	EFFECTIVE DATE	EXPIRATION DATE

ARE ANY RESIDENTIAL OR DAY PROGRAM SITES SERVICED BY A VOLUNTEER FIRE ASSOCIATION OR SUBSCRIPTION FIRE DEPARTMENT?

☐ Yes ☐ No If yes, attach documentation of current contract or proof of membership for each site, including proof of payment if paid by means other than city/county taxes.

FIRE/SAFETY INSPECTIONS

Fire/Safety Inspection:

- Prior to new construction, remodeling existing structures, and any structural alterations to existing facilities, the provider shall submit floor plans and specifications to the Department of Mental Health's Office of Licensure and Certification and the State Fire Marshal as required by 9 CSR 40-9.155 Fire Safety for On-Site Day Program.
- If a request for fire/safety inspection is required, the Office of Licensure & Certification will submit the request to the State Fire Marshal's Office after processing your completed application. Please complete the following form and have it on file at sites prior to the fire marshal inspection:

  http://dmh.mo.gov/docs/dd/forms/qa/fdnotify.pdf

Sites required to have a fire/safety inspection are:

- 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.

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.

THE COMPLETED APPLICATION PACKET SHOULD INCLUDE:

For INITIAL APPLICANTS:

- Completed application for licensure;
- A labelled floor plan of the facility with a narrative of how each room is used;
- Your staffing pattern, indicating the number of direct care staff on duty during each shift Monday through Sunday.

For RENEWAL APPLICANTS:

- Completed application for licensure.
- Updated floor plan ONLY if you are remodeling or changing the structure and use of your building.
- Your staffing pattern ONLY if it has changed within the last licensure cycle.

SEND THE COMPLETED APPLICATION PACKET AND LICENSURE FEE TO:
Missouri Department of Mental Health
Office of Licensure and Certification
1706 E. Elm Street • PO Box 687 • Jefferson City, MO 65102
Or email the completed application to: DMH-OLC@dmh.mo.gov
Questions: Call 573-751-4024

ACKNOWLEDGEMENT

STATE OF MISSOURI

CITY OF _____ COUNTY OF _____

_____ and _____
GOVERNING BODY PRESIDENT — 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

will be eligible for licensure only after it has complied with the requirements of the law and the regulations and codes, and that such licensure is subject to revocation at any time this agency fails to comply with the law, regulations and codes. Furthermore, it is agreed that the 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. _____ and _____ further
GOVERNING BODY PRESIDENT — CHIEF ADMINISTRATIVE OFFICER

certify that he/she will comply with all requirements, corrections and/or improvements in _____ contained
NAME OF APPLICANT OR AGENCY

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 PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		