Revenue Section
P.O. Box 1099
Olympia, WA 98507-1099
Toll Free # 1.800.771.1204
http://www.doh.wa.gov/hsqa/fsl

Residential Treatment Facility License Application Packet

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Important Information:

It is a violation of Washington State Law to operate without a current license.

Licenses are not transferable.

In order to process your request:

Return Completed Application, fee, and items on the checklist to:

Department of Health
Revenue Section
PO Box 1099
Olympia, WA 98504-1099

Facility Services & Licensing
PO Box 1099
Olympia, WA 98507-1099
Toll Free # 1.800.771.1204
http://www.doh.wa.gov/hsqa/fsl

Residential Treatment Facility License Application Checklist

Return the following to the above address:

- ☐ Signed Application.
- ☐ Copy of Master Business License.
- ☐ Applicable licensing fee listed on application.
- ☐ Room list identifying resident rooms, dimensions, and calculated square footage of each room, and number of approved bed spaces. Submit for each building.
- ☐ Reduced floor plan on letter size paper with identification of each room within the facility. Submit for each building.
- ☐ Criminal history background check and disclosure statement for the contact person in accordance with RCW43.43.

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Date Stamp Here

Fees	
Administrative Processing & Application Fee	$155.00
Licesing Fee per Bed	$144.60
Payable in US Funds	

Revenue: 0597634110

Residential Treatment Facility License Application

This is for: ☐ New ☐ Change of Ownership

Check One

- ☐ Association
- ☐ Corporation
- ☐ Federal Government Agency
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership
- ☐ Limited Partnership
- ☐ Municipality (City)
- ☐ Municipality (County)
- ☐ Non-Profit Corporation
- ☐ Partnership
- ☐ Sole Proprietor
- ☐ State Government Agency
- ☐ Tribal Government Agency
- ☐ Trust

1. Demographic Information

UBI #			**Federal Tax ID (FEIN) #**
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip	County
Phone #		Fax #	
Email Address		Web Address	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip	County
Facility Phone #		Fax #	
Mailing Address (If different than physical address)			
City	State	Zip	County

For Office Use Only

License # ______________________________

2. Site Information

Total Number of Licensed Beds________________

Check all service categories provided:

- ☐ Chemical Dependency Acute Detoxification
- ☐ Chemical Dependency Intensive Inpatient
- ☐ Chemical Dependency Long-Term Treatment
- ☐ Chemical Dependency Recovery House
- ☐ Chemical Dependency Sub-Acute Detoxification
- ☐ Mental Health Adult Residential Treatment
- ☐ Mental Health Child Inpatient Evaluation and Treatment
- ☐ Mental Health Child Long-Term Inpatient Treatment
- ☐ Mental Health Inpatient Evaluation and Treatment

Accreditation Agency 1 ______________________

Effective Date ______________________

Expiration Date ______________________

Accreditation Agency 2 ______________________

Effective Date ______________________

Expiration Date ______________________

Date opened (new facility) ____________________

3. Contact Person (the person responsible for the day-to-day operation)

Name	Title
WA State Professional License #	Phone

4. Additional Information

Do you have a campus of two or more buildings? ☐ No ☐ Yes

If yes, please attach a list of each building's name, address, and phone numbers.

Are the treatment services certified? ☐ DASA ☐ MHD ☐ Other ______________________

Legal Owner Information–attach additional sheets as needed

List names, addresses, phone numbers, and titles of corporate officers, partners, members, managers, etc.

Name	Address	Phone #	Title

Change of Ownership Information

Previous Name of Legal Owner

Previous Name of Facility	Previous RTF License #	Effective Date of Ownership Change

Physical Address

Signature

I certify that I have received, read, understood, and agree to comply with state law and rule regulating this licensing category. I also certify that the information herein submitted is true to the best of my knowledge and belief.

Signature of Owner/Authorized Representative	Date
Print Name	Print Title