



## **Residential Treatment Facility License Application Packet**

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### **Important Information:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Residential Treatment Facility  
Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360.236.4700

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## Application Checklist and Instructions

### General Information

When your application for Residential Treatment Facility is received by the Department of Health, you will be notified in writing of any outstanding documentation needed to complete the application process.

All information should be typed or printed clearly in ink. It is your responsibility to submit the required forms.

**Indicate type of application**—new or change of ownership.

- **New**—First time requesting a residential treatment facility license.
- **Change of Ownership**—When name of legal owner/operator changes resulting from the sale of licensed residential treatment facility.

**Check One:**

Please check your legal owner/operator business structure type according to your Washington State Master Business License.

**Application Fee:**

You can check the [Fee Page](#) for current fees.

**1. Demographic Information:**

**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #s. City, county, and state government departments also have UBI #s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/Master Business License.

**Mailing Address:** Enter the owner's complete mailing address.

**Phone, Fax and Cell Numbers:** Enter the owner's phone, cell, and fax numbers.

**Email and Web Address:** Enter the owner's email and facility Web addresses, if applicable.

**Facility/Agency Name:** Enter the agency's name as advertised on signs, brochures, or Web site.

**Physical Address:** Enter the agency's physical street location including city, state, zip code, and county.

**Phone, Fax and Cell Numbers:** Enter the facility's phone, cell, and fax numbers.

**Mailing Address:** Enter the facility's mailing address, if different than the physical address.

**2. Facility Specific Information:**

**A. In-patient beds:**

Indicate total number of licensed bed(s).

**B. Services provided:**

Check all that apply.

**C. Certification—Accreditation:**

List name of accreditation agency, last accreditation survey date, and expiration date.

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

Enter name, title, WA State professional license number, phone number, fax number, and email address.

**4. Additional Information:**

Legal Owner Information: List the names, titles, addresses, and phone numbers of the corporate officers, partners, members, and managers of the agency. Attach more sheets of paper as needed.

Change of Ownership Information: List the previous legal owner name, previous name of facility/agency, effective date of ownership change and physical address, if applicable.

**5. Signature:**

Signature of legal owner or authorized representative.

Date signed.

Print name of legal owner or authorized representative.

Print title of legal owner or authorized representative.

## **General Information**

Return completed application and the following information:

- Signed Application
- Copy of Master Business License
- Applicable licensing fee
- 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 (CBC):**—Attach a copy of the current CBC for the on-site Administrator/Director and owner dated within three months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in accordance with [RCW 43.43](#).
- **Disclosure Statement**—Attach a copy of the disclosure statement for the on-site Administrator/Director and owner dated within three months of the initial application date. Agencies must keep current copies of the disclosure statement on file as stated in accordance with [RCW 43.43](#).

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## Residential Treatment Facility License Application

This is for:    New    Change of Ownership

### Check One

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Association                   | <input type="checkbox"/> Limited Partnership    | <input type="checkbox"/> Sole Proprietor          |
| <input type="checkbox"/> Corporation                   | <input type="checkbox"/> Municipality (City)    | <input type="checkbox"/> State Government Agency  |
| <input type="checkbox"/> Federal Government Agency     | <input type="checkbox"/> Municipality (County)  | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company     | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust                    |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership            |   |

### 1. Demographic Information

UBI #		Federal Tax ID (FEIN) #	
Legal Owner/Operator Name			
Mailing Address			
City	State	Zip	County
Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Email address		Web Address	
Facility/Agency Name (Business name as advertised on signs or Web site)			
Physical Address			
City	State	Zip	County
Facility Phone (enter 10 digit #)		Fax (enter 10 digit #)	
Mailing Address			
City	State	Zip	County

#### For Office Use Only

License #

## 2. Site Information

Total Licensed Beds \_\_\_\_\_

**Check all service categories provided:**

Chemical Dependency Acute Detoxification

Mental Health Adult Residential Treatment

Chemical Dependency Intensive Inpatient

Mental Health Child Inpatient Evaluation and Treatment

Chemical Dependency Long-Term Treatment

Mental Health Child Long-Term Inpatient Treatment

Chemical Dependency Recovery House

Mental Health Inpatient Evaluation and Treatment

Chemical Dependency Sub-Acute Detoxification

Accreditation Agency 1 \_\_\_\_\_

Accreditation Agency 2 \_\_\_\_\_

Effective Date \_\_\_\_\_

Effective Date \_\_\_\_\_

Expiration 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 (enter 10 digit #)
Email Address	Fax # (enter 10 digit #)

## 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?  DSHS-DBHR-CD  DSHS-DBHR-MH  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 (enter 10 digit #)	Title

## Change of Ownership Information

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

Physical Address \_\_\_\_\_

## 5. 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 (mm/dd/yyyy)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title

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## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Residential Treatment Facility Laws (RCW) .....	<a href="#"><u>RCW 71.12</u></a>
Residential Treatment Facility Rules (WAC) .....	<a href="#"><u>WAC 246-337</u></a>
Residential Treatment Facility Fees (WAC) .....	<a href="#"><u>WAC 246-337-990</u></a>

### **On-Line**

Residential Treatment Facility .....	<a href="#"><u>Web Page</u></a>
Construction Review Services—Desk Reference Manual .....	<a href="#"><u>Desk Reference Manual</u></a>
Department of Social and Health Services—Behavioral Health and Recovery, Mental Health Agency Licensing, Substance Abuse Prevention and Treatment—Certification Services .....	<a href="#"><u>Substance Abuse</u></a>

### **List-Serv**

To receive emails regarding important residential treatment facility information, please join our interested parties at..... [List-Serv](#)