### Agency Remodel Approval Request Form

#### Section I: Demographic Information

<table>
<thead>
<tr>
<th>Association</th>
<th>Limited Partnership</th>
<th>Public Hospital District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporation</td>
<td>Municipality (City)</td>
<td>Sole Proprietor</td>
</tr>
<tr>
<td>Federal Government Agency</td>
<td>Municipality (County)</td>
<td>State Government Agency</td>
</tr>
<tr>
<td>Limited Liability Company</td>
<td>Non-Profit Corporation</td>
<td>Tribal Government Agency</td>
</tr>
<tr>
<td>Limited Liability Partnership</td>
<td>Partnership</td>
<td>Trust</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>UBI #</th>
<th>Federal Tax ID (FEIN) #</th>
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<table>
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<tr>
<th>Legal Owner/Operator Name</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
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</thead>
<tbody>
<tr>
<td>City</td>
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</table>

Name of Agency as advertised on signs or website:

<table>
<thead>
<tr>
<th>Physical Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
</tbody>
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Phone (enter 10 digit #): Fax number:

<table>
<thead>
<tr>
<th>Mailing Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
</tr>
</tbody>
</table>

Specify the date the remodel has or will occur:

Address for the treatment facility location:

| City: | State: | Zip Code: |
Remodel Information

Specify the date the remodel will occur. ________________________________

Please include an up-to-date floor plan showing the use and dimensions of each room and location of the following information:

- Windows and doors;
- Restrooms;
- Floor-to-ceiling walls;
- Reception area is separate from living and therapy areas;
- Areas serving as confidential counseling rooms;
- Adequate space for personal consultation with patient, staff charting, and other activities;
- Other therapy and recreation areas and rooms;
- Secure, confidential patient records storage; and,

For outpatient facilities, please complete and return the Accessibility Barrier Checklist.

The floor plan can be hand drawn. Please ensure it contains the above information.
A Sample Floor Plan and Accessibility Barrier Checklist can be downloaded on the Department of Health website.

Provide a written description of the changes and the purpose for the remodel:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

IV. Applicant Declarations
I declare the following:
• That I will notify the Department of Health if changes occur in any of the information provided in Parts 1 or 2 of this application before certification occurs.
• That none of the disqualifying conditions described in WAC 246-341-0335 has occurred.
• That the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.

Signature of Administrator or other legal representative: Date of signature:
Printed Name of Person Signing Form: Title:
Phone Number: Email

V. Applicant Contact Information
☐ Check here if same as above; if different, complete the below
Applicant’s Contact Name: Title:
Contact Phone Number: Email

Return this original request form, the floor plan of the remodeled facility, and the completed Accessibility Barrier Checklist to the address listed on page one.
RCW/WAC and Online Website Links

WAC Link

Behavioral Health Agency, Chapter 246-341 WAC

Online

Behavioral Health Agencies Web Page