Behavioral Health Agency Mobile/Fixed-Site Medication Unit Notification

Contents:

In order to process your request:

Mail your application with applicable documentation to:

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

Send other documents not sent with initial application to:

Behavioral Health Agency License Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Notification Checklist and Instructions

When your notification for a mobile or fixed-site medication unit is received by the Department of Health (DOH), you will be notified in writing if there is any outstanding documentation needed to complete the notification process. Once approved, DOH will notify you in writing that the mobile or fixed-site medication unit has been added under the behavioral health agency (BHA) license.

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

On page one of the application, indicate type of mobile or fixed-site medication unit - outpatient behavioral health or mobile narcotic treatment program.

- **Outpatient Behavioral Health Mobile Unit -** Provides certified services from a mobile unit as an extension of the existing BHA license.
- **Mobile Narcotic Treatment Program -** Provides certified opioid treatment program (OTP) services as an extension of the existing BHA license and OTP certification.
- **Fixed-Site Medication Unit -** Provides certified opioid treatment program (OTP) services as part of the existing BHA license and OTP certification at a location that is geographically separate from the main site.

☐ **Section I: Main Site Information**: Please list the BHA license number and address that the mobile or fixed-site medication unit will be operating under.

☐ **Section II: Mobile Unit Vehicle Information:** Please list the vehicle make/model and year, Vehicle Identification Number (VIN), and license plate number.

☐ **Section III: Fixed-site Medication Unit Information:** Please list the pharmacy Drug Other Controlled Substance (DRCS) credential number and the address where the medication unit will be operating.

☐ **Section IV: Agency Information:** Enter name, email address, and phone number for the administrator and contact person that the department can contact about this notification.

☐ **Section V: Certification and Services Information:** Check the box beside each specific certification and service your mobile or fixed-site medication unit is providing.

- **Certifications:** Certification categories of services are bolded.
- **Services:** Services are types of supports, interventions, or treatments provided under a certification.

*** Note: The mobile or fixed-site medication unit may only provide services for which the BHA is currently certified to provide. If the mobile or fixed-site medication unit will be providing additional services, an application to add services to the BHA license must be received before the mobile or fixed-site medication unit will be approved.***

☐ **Opioid Treatment Program Services:** Check the box if your agency is providing OTP services in the mobile or fixed-site medication unit.

- Enter the OTP Sponsor name, title, phone and email address
- Enter OTP Medical Director name, title, phone and email address

Washington State Department of HEALTH

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Behavioral Health Agency (BHA) Mobile Unit Notification

☐ Behavioral Health Mobile Unit ☐ Mobile Narcotic Treatment Program ☐ Fixed-Site Medication Unit

Section I: BHA Site Information		
BHA Credential Number:		
Address:		
City	State	Zip Code
Section II: Mobile Unit Information		
Vehicle Make/Model:		
Vehicle Identification Number (VIN):		
License Plate Number		
Section III: Fixed-Site Medication Unit Information:		
Pharmacy Drug Other Controlled Substance (DRCS) Credential Number:		
Address:		
City:	State:	Zip Code:
Section IV: Agency Information		
Agency Administrator		
Name:	Email:	Phone:
Agency Contact Person		
Name:	Email:	Phone:

Section IV: Certification and Services Information

☐	**Certification: Behavioral Health Information Assistance**	
☐	Crisis Telephone Support	☐ MH ☐ SUD
☐	**Certification: Behavioral Health Support**	
☐	Psychiatric Medication Monitoring	
☐	Crisis Support	☐ MH ☐ SUD
☐	Peer Support	☐ MH ☐ SUD
☐	Rehabilitative Case Management	
☐	Supportive Housing	☐ MH ☐ SUD
☐	Supported Employment	☐ MH ☐ SUD
☐	**Certification: Behavioral health Outpatient Intervention, Assessment, and Treatment**	
☐	Assessments	☐ MH ☐ SUD
☐	Counseling and Therapy	☐ MH ☐ SUD
☐	Psychiatric Medication Management	
☐	Outpatient Involuntary Court-Ordered Services - LRA/Conditional Release	☐ MH ☐ SUD
☐	Outpatient Involuntary Court-Ordered Services - DUI Assessment	
☐	Outpatient Involuntary Court-Ordered Services - Deferred Prosecution	
☐	Outpatient Involuntary Court-Ordered Services - SUD Counseling under RCW 41.61.5056	
☐	Outpatient Involuntary Court-Ordered Services - Alcohol and Drug Information School	

☐	**Certification: Behavioral Health Outpatient Crisis, Observation, and Intervention**
☐	**Certification: Designation Crisis Responder Services**
☐	**Certification: Problem Gambling and Gambling Disorder**
☐	**Certification: Applied Behavior Analysis**
☐	**Certification: Opioid Treatment Program**

OTP Sponsor Name:	Title:
Phone:	Email:
OTP Medical Director Name:	Title:
Phone:	Email:

Applicant Declarations

I declare the following:

- That I will notify the department if changes occur in any of the information provided in sections I and/or II of this application before licensure and certification is granted.
- That no person named in this application has had a license or certification for a treatment service or health care agency denied, revoked, or suspended.
- That no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse.
- That no person or business entity named in this application is currently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in transactions involving certain federal funds.
- That no person or business entity named in this application is currently under investigation for or has committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW 18.130.180.
- 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.
- That this agency meets Americans with Disabilities Act (ADA) standards and that the facility is: Suitable for the purposes intended; Not a personal residence; and Approved as meeting all building and safety requirements.

Signature of Administrator or Legal Representative	Date Signed
Printed Name of Person Signing Form	Title

Phone Number	Email

RCW/WAC and Online Website Links

WAC Link

Behavioral Health Agency Licensing and Certification Requirements, Chapter 246-341 WAC

Online

Behavioral Health Agencies Web Page