



**State of Idaho**  
 Department of Health and Welfare  
 Division of Behavioral Health (DBH)  
 Application for Behavioral Health Program Approval

<i>DBH Use Only</i>
Date _____ Fee Rec'd \$ _____
Date to PS _____ Initials _____

<b>PROGRAM INFORMATION</b>	
Program Name _____	Program Administrator _____
Mailing Address _____	City, State, Zip _____
Telephone _____	Email _____ # of sites to be approved _____
Type (if applicable): <input type="checkbox"/> Medicaid/Optum Idaho <input type="checkbox"/> Nationally Accredited <input type="checkbox"/> Indian Health Service (IHS)	

<b>Please assemble the required items, read and initial the required declarations/attestations, and submit to the address at the bottom of the application.</b>
<input type="checkbox"/> Initial Application <input type="checkbox"/> Renewal
Applications must include:
<b>For all applications (initial and renewal):</b> <ul style="list-style-type: none"> <li>The application fee of one hundred dollars (\$100) per location made out to: IDHW (110.03).</li> <li>An Organizational chart indicating all staff titles, locations employed, and applicable occupational licenses/certifications held (140.04.a).</li> <li>A copy of Medicaid IBHP Optum Idaho audit findings letter (110.08), if contracted with Optum.</li> <li>Verification of agency professional liability insurance <u>and</u> general liability insurance (110.06).</li> <li>Verification of fire inspection by the State Fire Marshal or designee for each facility (110.05.b).</li> <li>Verification of DHW criminal history unit clearance, or waiver, for each staff member (140.04.b).</li> </ul> <b>For initial applications only:</b> <ul style="list-style-type: none"> <li>A copy of the "Certificate of Assumed Business Name" from the Idaho Secretary of State (110.04), if applicable.</li> <li>A copy of the Certificate of Occupancy from the local building authority for each facility (110.05.a).</li> </ul> <b>For renewal applications only :</b> <ul style="list-style-type: none"> <li>Include information about any changes to the program that have occurred since certification period (120.04)</li> </ul> <b>If nationally accredited, an Indian Health Service, or tribal program please provide the following:</b> <ul style="list-style-type: none"> <li>A copy of accreditation results <u>or</u> verification of Indian Health Service behavioral health program or tribal designation (140.03).</li> </ul>

**The program administrator must initial each of the following.**

Initials	<b>ATTESTATIONS/DECLARATIONS (please initial each item)</b>
	I will notify the DBH, or its designee, of changes to any of the information provided before agency approval/ renewal is granted (120.04)
	I authorize the DBH, or its designee, to perform a site inspection of all program sites named herein, including access to all facilities, personnel records, policies, and client files (110.07)
	No owner, applicant, or administrator named herein has been found guilty of fraud, deceit, misrepresentation, or dishonesty associated with the operation of a program (201.02.b.ii)
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.300. PROGRAM ADMINISTRATION REQUIREMENTS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.310. DESCRIPTION OF SERVICES.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.320. ADMISSION POLICIES AND PROCEDURES.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.330. QUALITY ASSURANCE.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.340. ASSESSMENT.
	I have read, understand, and agree to comply with the requirements set forth in the following section

of IDAPA: 16.07.15.341. INDIVIDUALIZED SERVICE PLANS.
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Initials	ATTESTATIONS/DECLARATIONS (please initial each item)
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.350. CRISIS INTERVENTION AND RESPONSE.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.360. PARTICIPANT RECORDS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.370. PARTICIPANT RIGHTS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.380. ADMINISTRATION OF MEDICATIONS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.390. PERSONNEL POLICIES AND PROCEDURES.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.391. STAFFING AND SUPERVISION.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.395. INFECTION CONTROL.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.400. ENVIRONMENT REQUIREMENTS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.410. EMERGENCY PREPAREDNESS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.411. MEDICAL EMERGENCY SERVICES.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.412. CRITICAL INCIDENT PREPAREDNESS.
	I have read, understand, and agree to comply with the requirements set forth in the following section of IDAPA: 16.07.15.420. FACILITY REQUIREMENTS.

**Please provide information below for each treatment site to be approved (copy as necessary).**

PRIMARY FACILITY		
Address	City, State, Zip	Phone
Email		
Clinical Supervisor	Population(s) served at location: <input type="checkbox"/> Adults <input type="checkbox"/> Adolescents	
FACILITY # _____		
Address	City, State, Zip	Phone
Email		
Clinical Supervisor	Population(s) served at location: <input type="checkbox"/> Adults <input type="checkbox"/> Adolescents	
FACILITY # _____		
Address	City, State, Zip	Phone
Email		
Clinical Supervisor	Population(s) served at location: <input type="checkbox"/> Adults <input type="checkbox"/> Adolescents	

I certify that the information contained herein, and attached to this application, is true, complete, and correct to the best of my knowledge. I hereby make application for approval (or renewal) of a Behavioral Health Program, subject to the provisions of Idaho Code, and IDAPA 16.07.15 (Behavioral Health Programs).

\_\_\_\_\_  
Signature of Program Administrator

\_\_\_\_\_  
Date

Mail to:  
IDHW-Division of Behavioral Health  
Behavioral Health Program Approval  
PO Box 83720  
Boise, ID 83720-0036

Please call 208.334.6662, toll free 800.264.6979, or email [BHIDAPAQuestions@dhw.idaho.gov](mailto:BHIDAPAQuestions@dhw.idaho.gov) with questions.