North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure & Certification Section

Initial
Licensure Application Packet

Form# DHHS/DHSR/MHL5001
Revised 11/15/2024

Mental Health Licensure and Certification Section
www.ncdhhs.gov/dhsr
Tel 919-855-3795 • Fax 919-715-8078
Location: Williams Building • 1800 Umstead Drive • Raleigh, NC 27603
Mailing Address: 1800 Umstead Drive • 2718 Mail Service Center • Raleigh, NC 27699-2718
An Equal Opportunity / Affirmative Action Employer

N.C. Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
1800 Umstead Drive ■ 2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

Memorandum

To: Mental Health, Developmental Disabilities, and Substance Abuse Facility Licensure Applicants
From: Mental Health Licensure and Certification Section
Re: Initial Licensure Application Packet

You may find helpful information regarding how to establish a mental health facility on our DHSR website. The Facility Licensure Information link and The F and Q pages are great resources to review.

Enclosed you will find an Initial Licensure Application Packet. The packet includes the following:

- Licensure Application Process
- Initial Licensure Application
- Photographs sheet
- MH Licensure Policies and Procedures Worksheets

The following rules are essential for all licensed mental health facilities to help formulate the required Operations and Management Policies, Guidelines and Procedures (download for free at http://www.ncdhhs.gov/dhsr/mhlcs/rules.html).

- 10A NCAC Chapter 26 Mental Health, General
  Subchapter C Other General Rules
- 10A NCAC Chapter 27 Mental Health, Community Facilities and Services
  Subchapter C Procedures and General Information
  Subchapter D General Rights
  Subchapter E Treatment or Habilitation Rights
  Subchapter F 24-Hour Facilities
  Subchapter G Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services

Hard copies of these rules may be ordered from the Division of MH/DD/SAS:

- Phone: 984-236-5000
- E-mail: contactdmh@dhhs.nc.gov
- Mailing Address: 3001 Mail Service Center, Raleigh NC 27699-3001 (checks or money orders only made payable to Division of Mental Health)

The following NC General Statutes are essential for all licensed mental health facilities. Below is not an all-inclusive list; a complete list of NC General Statutes that govern licensed facilities are found at http://www.ncleg.net/gascripts/Statutes/StatutesTOC.pl

- NC GS 122C 6: Smoking Prohibited
- NC GS 122C 61: Treatment rights in 24-hour facilities
- NC GS 122C 62: Additional rights in 24-hour facilities
- NC GS 122C 63 Assurance for Continuity of Care for Individuals with Mental Retardation
- NC GS 122C 80 Criminal History; Record Check
- NC GS 131E 256 Health Care Personnel Registry

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LICENSE APPLICATION PROCESS

An applicant is allowed six months from the date contact is made with applicant and a Licensure & Training team member to complete all requirements of application review to obtain a license. After initial licensure, the facility must have the license renewed every year.

In order to apply for a license from the Division of Health Service Regulation to operate a mental health facility as required under General Statute 122C, you must do the following:

1. *Complete the application*
   (a) 24-hour Residential Programs:
   - ***Take the completed application (pages 9-14) to your local zoning office and obtain zoning compliance. Attach the zoning compliance letter to the application.***

   - ***The zoning compliance letter from your local zoning department must clearly identify:***
     - ***Facility address***
     - ***Zoning code (must be correct zoning code see below chart)***
     - ***Intended usage***

Your application will not be processed if your zoning compliance information does not contain and verify the correct zoning.

- Take the completed application (pages 9-14) to your area Local Management Entity-Managed Care Organization (LME-MCO) office and obtain a Letter of Support as per 10A NCAC 27G .0406. Attach LME-MCO support letter to the application. A Letter of Support is not required for services that have a Certificate of Need (CON) from DHSR, which currently is ICF/IID facilities.
- Submit all items listed in the **Requirements for 24-hour Residential Programs** box on page 7.
- Include initial licensure fee upon submitting all items.

(b) Day Programs:

- **Take the completed application (pages 9-14) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.**
- State Opioid Treatment Authority (SOTA) requires a preliminary program approval letter for all service category 3600 facilities.
- Submit all items listed in the **Requirements for Day Programs** box on page 8, including approved Fire Marshal, Sanitation and Building Officials inspection reports as required.
- Include initial licensure fee upon submitting all items.

2. Write a letter briefly describing the services you will offer at the proposed facility.
3. Develop written policies and procedures for your service. Do not submit your organization's P&P with the application, as they will be reviewed later.
4. Make check payable to: **NC Division of Health Service Regulation**
5. Send application with the required information to: Division of Health Service Regulation
   MH Licensure & Certification Section
   1800 Umstead Drive
   2718 Mail Service Center
   Raleigh, NC 27699-2718

Note:** Before the construction of a ***new residential facility, you must submit blueprints and receive approval from the DHSR Construction Section. For information, contact DHSR Construction at 919-855-3893.

N.C. Department of Health and Human Services

Division of Health Service Regulation
Mental Health Licensure and Certification Section
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Building Code Zoning Classifications - Requirements for Licensure Categories (revised 8-8-2013)

Program Code 10 NCAC 27G	Facility Type	Residential/ Institutional 24 hour programs	Building Classification	Code
.1100	Partial Hospitalization for individuals who are acutely mentally ill	No	Group B – Business Occupancy (Adults) Group E – Educational or I4 (minors)	a
.1200	Psychosocial Rehab for individuals with Severe and Persistent Mental Illness	No	Group B – Business Occupancy	a
.1300	Residential Treatment for Children or Adolescents	Yes	Residential – Classification dependent on number & ambulation status	b
.1400	Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances	No	Group E – Educational Occupancy or I-4	a
.1700	Residential Treatment Staff Secure for Children or Adolescents	Yes	Residential – Classification dependent on number & ambulation status	d
.1800	Intensive Residential Treatment for Children or Adolescents	Yes	Institutional Occupancy	e
.1900	Psychiatric Residential Treatment for Children and Adolescents	Yes	Institutional Occupancy	f
.2100	Specialized Community Residential Centers for Individuals with Developmental Disabilities	Yes	Residential or Institutional Occupancy	g
.2200	Before/After School and Summer Developmental Day Services for Children with or at Risk for Developmental Delays, Developmental Disabilities, or Atypical Development	No	Group E- Educational or I-4	a
.2300	Adult Developmental and Vocational Program for Individuals with Developmental Disabilities	No	Group B- Business Occupancy	a
.3100	Nonhospital Medical Detoxification for Individuals who are Substance Abusers	Yes	Institutional Occupancy	h
.3200	Social Setting Detoxification for Substance Abusers	Yes	Residential or Institutional Occupancy	m
.3300	Outpatient Detoxification for Substance Abuse	No	Group B – Business Occupancy	a
.3400	Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders	Yes	Residential or Institutional Occupancy	i
.3600	Outpatient Opioid Treatment	No	Group B- Business Occupancy	a
.3700	Day Treatment Facilities for Individuals with Substance Abuse Disorders	No	Group B- Business Occupancy Group E – Educational or I4 (Minors)	a
.4100	Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children	Yes	Typically Group R – Residential	j
.4300	Therapeutic Community	Yes	Typically Group R – Residential	k
.4400	Substance Abuse Intensive Outpatient Program (SAIOP)	No	Group B – Business Occupancy (Adults) Group E – Educational or I4 (minors)	a

N.C. Department of Health and Human Services
Division of Health Service Regulation
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.4500	Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	No	Group B- Business Occupancy	a
.5000	Facility-Based Crisis Services for Individuals of All Disability Groups	Yes	Institutional Occupancy	l
.5100	Community Respite Services for Individuals of All Disability Groups	Yes	Typically Residential depending on the number of residents	m
.5200	Residential Therapeutic (Habilitative) Camps for Children and Adolescents of All Disability Groups	Yes	Wilderness Camp Settings	p
.5400	Day Activity For Individuals of All Disability Groups	No	Group B- Business Occupancy Group E – Educational or I4 (Minors)	a
.5500	Sheltered Workshops For Individuals of All Disability Groups	No	Group B- Business Occupancy	a
.5600	Supervised Living For Individuals of All Disability Groups	Yes	Residential	o
.6000	Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders	Yes	Institutional Occupancy	l

Code	Program Type / Description
a	Day Program
b	Level II Clients
c	This program has been deleted
d	Level II clients (previously part of the .1300 program)
e	Level IV clients. Required to be a secured facility and Institutional – Unrestrained Occupancy (previously part of the .1500 program)
f	PRTF clients. May be staff secured or locked; still Institutional – Unrestrained Occupancy (previously part of the .1500 program)
g	Usually these are ICF/IID facilities and required to have a Certificate of Need (CON)
h	Institutional occupancy since providing medical treatment
i	Typically, not in a six-bed facility since requires CON
j	Program is for women and their children. Usually in apartment/motel situation but if less than six could be a home
K	Program is for adults and is usually in apartment/ motel situation but if less than six could be in a home
l	Requires Institutional Occupancy since requiring treatment
m	Typically, is a resident with another residential program. Could be part of a larger facility not residential
n	Support Services, not residential
o	Has six different programs. .5600A; .5600B; .5600C are limited to maximum of 6 clients. .5600F is limited to maximum of 3 clients in private residence.
p	Residential Camp
q	Any program not listed is not a licensed program by Mental Health

Programs typically licensed in Single-Family Dwellings and falling under G.S. 168 are: .1300, .1700, .2100, .5100 & .5600.

License Fees: Initial License & Construction

All licensed facilities, residential and non-residential are required to pay an initial license and annual license renewal fee. NC General Statute 122C-23:

- Prohibits the issuance of the license until the license fee is paid.
- Mandates that licenses must be renewed annually and will expire at the end of the calendar year.

Please submit the Licensure fee with the application. Do not submit the Construction fee. Our Construction section will bill you for the applicable fee prior to conducting their site visit.

Initial Licensure Fee NC General Statute 131E-272: Following is a list of types of facilities with required fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	$265.00	N/A
Residential Facilities (Non-ICF/IID)	6 beds or less	$350.00	$0
Residential Facilities (Non-ICF/IID)	7 beds or more	$525.00	$19.00
ICF/IID* Facilities	6 beds or less	$900.00	$0
ICF/IID* Facilities	7 beds or more	$850.00	$19.00

*ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities, a specialized Medicaid facility requiring a Certificate of Need from the DHSR Certificate of Need Section.

Construction Fees: In addition to the license fee, the DHSR Construction Section has a per project fee to review the physical plant requirements for ***24-hour residential facilities only*.** You will receive an invoice from the Construction Section for the appropriate fee. Following is a list of fees:

Type of Facility	Number of Beds	Project Fee
Non-ICF/IID Facilities	1-3	$125.00
Non-ICF/IID Facilities	4-6	$225.00
Non-ICF/IID Facilities	7-9	$275.00
ICF/IID Facilities	1-6	$350.00
Other Residential	10 or more	$275.00 + $.15/sq. Ft. project space

Contact Information

For questions regarding any part of this process, please contact the appropriate section of the Division of Health Service Regulation or visit our website https://.info.ncdhhs.gov/dhsr/

Mental Health Licensure and Certification Section	919-855-3795
Construction Section	919-855-3893

License Application Requirements & Checklists

Incomplete applications will be returned to the sender, without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the appropriate checklist prior to submitting your license application

Requirements for 24-hour Residential Programs—Existing Structures

Note: Before the construction of a ***new 24-hour residential*** facility, you must submit blueprints and receive approval from the DHSR Construction Section. For additional information, contact DHSR Construction at 919-855-3893.

Please submit the information below:

1. A floor plan that specifies the following:
   a) All levels, including basements and upstairs.
   b) Identification and dimensions of the use of all rooms/spaces.
   c) Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
   d) Location of all doors and the dimensions of all exterior doors.
   e) Location of all windows, including bedroom windows and sill height of bedroom windows above the finished floor.
   f) Location of all smoke detectors noting whether they are battery-operated, wired into the house current with battery backup, and if they are interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Provide current *Secretary of State Report* (https://www.sosnc.gov/corporations) documenting Active Status.
5. **Local Zoning Department approval** for the proposed use**.**
6. Letter of support from LME/MCO. Not required for ICF-IID facilities.
7. Certificate of Need: Required for any new ICF/IID facilities.
8. Appointments for Fire & Sanitation Inspections.

24-Hour Residential Checklist

	Item	Completed
1.	Provide current Secretary of State Report (https://www.sosnc.gov/corporations) documenting Active Status.	
2.	Completed Initial Licensure Application (form DHSR 5001)	
3.	Fee	
4.	Floor Plan Identifying all spaces in the facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
5.	Pictures (Interior & Exterior)	
6..	Directions to Facility if not findable on google maps	
7.	Zoning Approval (original) *Required for application to move forward*	
8.	LME-MCO Support Letter if not ICF-IID	
9.	Certificate of Need: If ICF-IID Facility	
10.	Appointments for Fire & Sanitation Inspections. Actual inspections are not needed when submitting the application but will be needed prior to DHSR Construction section approval.	

Requirements for Day Programs

Note: Day Programs for children and adolescents ***cannot*** be located in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.

Please submit the following below:

1. A floor plan of the entire building or floor within the building of the space to be licensed that specifies the following:
   a. Identification and dimensions of rooms to be licensed.
   b. Exits from the licensed space and building.
   c. Toilet areas and other required support spaces.
2. Exterior photos of each side of the building. Interior photos of the proposed licensed space.
3. Provide current *Secretary of State Report* (https://www.sosnc.gov/corporations) documenting Active Status.
4. Local Zoning Department approval or verification that the facility is classified under building/planning for the intended use.
5. Current local Fire Marshal's Inspection Report for the building.
6. Current local Sanitation Inspection report if serving any food.
7. A preliminary program approval letter is required from the State Opioid Treatment Authority (SOTA) for all Service Category 3600 facilities.
8. New Construction/Renovation: the local Building Officials approval.
9. Existing Structure: If this is an existing Business Occupancy building (as classified under the North Carolina state building code) and it is only a change of tenant use (for a program that is classified as a 'Business Occupancy use') approval from the local Building Official may not be required. Contact your local Building Official and provide them with a copy of your application to verify if your program is classified as a Business Occupancy and if they need to provide any type of documentation.

Day Program Checklist

	Item	Completed
1.	Secretary of State Report (https://www.sosnc.gov/corporations) documenting Active Status.	
2.	Completed Initial Licensure Application (form DHSR 5001)	
3.	Fee	
4.	Floor Plan with dimensions	
5.	Pictures (Interior & Exterior)	
6.	Directions to Facility if not findable using google maps	
7.	Zoning Approval (original) ***Required for application to move forward***	
8.	Fire Inspection (clear copy or original)	
9.	Sanitation Inspection (clear copy or original) if serving food	
10.	Preliminary Program approval from SOTA (service category 3600)	
11.	Building Inspection (original) if applicable for new construction or renovation of building	

INITIAL LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

Include First Name, Middle Initial & Last Name for ***every person*** listed in the application

Fillable Form

Office use only: *License Number:* MHL#_____ FID# _____

1. **FACILITY NAME:** _____
   Name which the facility is advertised or presented to the public. This is the name that will be printed on your license. Refer to this facility name in **all** inquiries.

2. **FACILITY SITE ADDRESS: (NO P.O. BOXES)**

Street Address: _____

City: _____State: _____Zip Code: _____County:_____

Phone: _____Email:_____

* ***Must have an operable facility designated telephone that is clearly visible, accessible, on site and available 24 hours***.

3. **FACILITY CORRESPONDENCE MAILING ADDRESS:**

Name of Contact Person (Identified person will oversee application process): _____

Street Address: _____

City: _____State: _____Zip Code: _____

Phone: _____Email:_____

4. **NAME OF FACILITY DIRECTOR**: (First, MI, Last)_____

5. **SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY:** The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G. ***ALL APPLICATIONS MUST HAVE AN ORIGINAL SIGNATURE***

Name: (First, MI, Last) _____

Signature:_____Title:_____ Date:_____

OFFICIAL USE ONLY:

Licensure Categories:_____ ***Check #*** _____ ***Check Amount*** _____

SOS ☐ **P Request:**_____

PPT ☐

MFF ☐

ACCESS ☐

ACO ☐

Staff Initials: ☐

Remarks: _____

6. MANAGEMENT COMPANY: If the facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:
Name of Company/Contact Person: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

7. LOCAL MANAGEMENT ENTITY/ MANAGED CARE ORGANIZATION (LME/MCO) (List name(s) of LME/MCOs with which the facility has a contract):_____

8. LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

The full legal name of the individual, partnership, corporation or other legal entity, which owns the mental health facility business, is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for the financial and contractual obligations of the business and will be **recorded as the licensee on the license**.
(a) Name of Owner/Corporation: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

(b) Federal Tax ID number of Owner/Licensee:_____

(c) NATIONAL PROVIDER IDENTIFIER (NPI):_____

For Health Care Providers

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**. If you have questions or need additional information regarding the NPI number, call the toll-free number 1-800-465-3203 or visit the website: https://medicaid.ncdhhs.gov/claims-and-billing/national-provider-identifier
http://www.ncdhhs.gov/dma/NPI/index.htm

(d) Legal entity is: ☐ For Profit ☐ Not for Profit

(e) Legal entity is: ☐ Proprietorship
☐ Corporation ☐ Limited Liability Company
☐ Partnership ☐ Limited Liability Partnership
☐ Government Unit ☐ Professional Limited Liability Company

(f) Name of CEO/President: :(First, MI, Last) _____

Title:_____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Building Owner: If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, please provide the following information:

Name of Building Owner: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____Lease expires:

_____

9. OWNERS, PRINCIPLES, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only)

For-Profit Individuals or Companies

Complete the information below on **all** individuals who are owners, principles, affiliates or shareholders **holding an interest of 5% or more of the licensing entity listed on page 2**. Attach additional pages if necessary. If you are the only owner, complete the information below, listing the percentage interest as 100%.

Shareholder Name: (First, MI, Last)

_____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: (First, MI, Last)

_____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: (First, MI, Last)

_____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Non-Profit Companies and For-Profit Companies (If no individual holds an interest of 5% or more, please sign the statement below.)

There are **no owners, principles, affiliates or shareholders who hold an interest of 5% or more** of the licensing entity applying for or renewing a license:

Signature_____ Title _____ Date _____

10. SERVICE CATEGORIES:

Services subject to licensure under GS 122C are shown in the table below and are **found in the Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.1100 Partial hospitalizations for individuals who are acutely mentally ill. ***Does not encompass SUD as a primary D/O***	☐			
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness	☐			
.1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients)	☐			
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances	☐			
.1700 Residential treatment Staff Secure for Children or Adolescents—Level III (Max of 12 clients)	☐			
.1800 Intensive residential treatment for children or adolescents (Level IV)	☐			
.1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness.	☐			
.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required if ICF/IID)	☐			
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development	☐			
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities	☐			
.3100 Non-hospital medical detoxification for individuals who are substance abusers	☐			
.3200 Social setting detoxification for substance abuse	☐			
.3300 Outpatient detoxification for substance abuse	☐			
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders	☐			
.3600 Outpatient narcotic addiction treatment (preliminary SOTA Authorization letter required)	☐			
.3700 Day treatment facilities for individuals with substance abuse disorders	☐			
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients)	☐			
.4300 A supervised therapeutic community for individuals with substance abuse disorder	☐			
.4400 Substance Abuse Intensive Outpatient Program	☐			
.4500 Substance Abuse Comprehensive Outpatient is a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery.	☐			

Fillable Form

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Policies and Procedures: Initial Licensure Survey

Rule 10A NCAC 27G Licensure Rules for Mental Health Facilities	Check Service of License	Beds Assigned by Age 0-17	18 & up	Total Beds
.5000 facility based crisis service for individuals of all disability groups	☐			
.5100 Community Respite services for individuals of all disability groups	☐			
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups	☐			
.5400 Day activity for individuals of all disability groups	☐			
.5500 Sheltered workshops for individuals of all disability groups	☐			
. 5600 supervised living for individuals of all disability groups – NOTE: Only *one* category (A, B, C, D, E or F) can be checked for .5600 facilities				
5600**A** Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients)	☐			
5600**B** Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) (CON required only if ICF/IID)	☐			
.5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) (CON required only if ICF/IID)	☐			
.5600**D** Group homes for minors with substance abuse problems	☐			
.5600**E** Half-way houses for adults with substance abuse problems	☐			
.5600**F** Alternative family living – providing service in own private residence (Max. 3 clients)	☐			

11. DO YOU HAVE A CERTIFICATE OF NEED? *Required* for ICF/IID Facilities (program code .2100 or .5600C)

☐ No Yes ☐ If yes, CON Number: _____ Date CON Received: _____

12. Do you plan on serving clients requiring blood sugar checks? Yes ☐ No ☐

*If yes **and** your staff will be conducting blood sugar checks, you must apply for a CLIA waiver before conducting blood sugar checks. Please contact DHSR's Acute & Home Care section's CLIA branch for information on obtaining CLIA waiver: https://info.ncdhhs.gov/dhsr/ahc/clia/index.html

13. NUMBER OF CLIENTS FOR WHICH THE FACILITY IS GOING TO BE LICENSED:

Type	**Specify Number to be Licensed**
Ambulatory*	
Non-Ambulatory, 1-3	
Non-Ambulatory, 4 or more	

Ambulatory: Is a person who can evacuate the facility without physical or verbal assistance during a fire or other emergency.

14. NUMBER AND AGE(s) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:
(Applicable only in categories where a private residence is allowable: .5600F & .5100 Private Home Respites)

_____

Are any of the above people listed non-ambulatory? Yes ☐ No ☐

An interpretation the NC Department of Insurance determined in June of 1998. that any child under the age of six residing in a licensed Home (MHL, FCH or Child Care etc.) is considered non-ambulatory and, as such, must be considered as part of the home's licensed census, as the child will require attention in addition, to the care the licensed clients of the home will also require, this would also apply for an aged or disabled family member that needs assistance residing the home.

PHYSICAL PLANT

Please fill in information for **each** inspection Department:

Zoning Department Official

Department Name: _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Local Building Official

Department Name: _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Local Fire Marshall

Department Name: _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Local Sanitation

Department Name: _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Building Information: Complete for 24-hour residential facilities only:

Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility: _____

Previous License #: _____ Dates of Licensure: From: _____ To: _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If yes, please clarify type of license _____

Is the building a site constructed home or a manufactured/mobile home? _____

NOTE: If it is a manufactured/mobile home, contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐

PHOTOGRAPHS

Name of Facility: _____

County: _____

Please attach/insert photos of your facility, as required, to this sheet and add other blank sheets as needed. **Please label each photograph as to the identity of the room** within the facility. **{If original photos are submitted on the back of the photo, identify with the name and address of the facility** (to help identify pictures should photos get separated)}.

D O NOT SEND Policies and Procedures with this applciation

An applicant is allowed six months from the date contact is made with applicant and a Licensure & Training team member to complete the program review of the application process.

- A person from the L&T team will contact you to begin the program review. Y***our six months' time frame begins from the initial contact with the L&T team member.***
- ***Please note if you are a residential service, the application must be processed with DHSR construction. DHSR construction time is separate from the MHLC timeframe.***
- The amount of time it takes to complete an application process is driven by the readiness of the applicant
- The L&T Team has a goal to get you licensed a lot sooner than 6 months, but you must be ready for the Licensure & Team Program Review to do this.

A full list of the required materials that will be reviewed can be found on the DHSR website under the forms and applications section. In addition, the policies and procedures worksheet that must accompany your policies and procedures can be found under the forms and applications section.