SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH	**Application for Licensure as a Facility for Chemically Dependent or Addicted Persons – Outpatient Facility Regulation 60-93**

RETURN COMPLETED APPLICATION TO:

Email address: (preferred method) CDAP@dph.sc.gov	Mailing Address: Bureau of Health Facilities Licensing P.O. Box 2046 West Columbia, SC 29171
For additional questions, contact us at: 803-545-4370.	

INSTRUCTIONS:

Your license must be renewed prior to the expiration date. Each licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or capacity increases/decreases) from the Department that are in progress at the time the license is due for renewal.

The application must be complete and legible. Any missing information may result in delays in processing this application. Any section that requires additional space or documentation shall be included as an attachment on an 8.5" x 11" paper and labeled to identify to which section the additional material pertains. Proof of payment is required for all applications submitted.

Part A: Reason for Application

- Initial: Check this box only if this is the first time you are applying for a license with the Department.
- Renewal: Check this box only if you are renewing your license. Enter the license number and expiration date. The name of the facility must appear on this application exactly as it did the prior year.
- Amended License: Check this box if you are applying for a change in, location, facility name, or facility service type. Enter the license number and expiration date.
- Change of Licensee: Check this box only if there is a change of ownership or the type of legal entity. Enter the license number and expiration date.

Part B: Facility Information

- Complete the information regarding the facility. For facilities that are already licensed, the name of the facility must match exactly what is on the current license.
- Check Opioid Treatment Program **only** if you are providing services using Methadone or other opioid treatment medication, and offering a range of treatment procedures and services for the rehabilitation of persons dependent on opium, morphine, heroin, or any derivative or synthetic Controlled Substance of that group (see Section 101.PP of regulation).
- Complete the information regarding the contact person where all communication, including the license, will be sent.
- Complete information regarding the Administrator.

Part C: Satellite Facilities

- Indicate if the satellite facility is a medication unit or a satellite location (see Section 101.KK and 101.AAA of regulation for definitions and 102.D for regulatory requirements).
- Complete the information regarding the facility.

Part D: Licensee/Owner Information

- Renewal and Relocation Applicants do not need to complete this section if they can attest that there is no change in ownership by checking the box.
- Complete the ownership information. (Name of the person(s) or legal entity licensed to operate the business at that site as indicated in Part B. (This can be found on your current license or your documentation from the Secretary of State.)
- Indicate the ownership type.
- Complete the requested information:
    - For partnerships, you must provide the name of each partner;
    - For limited liability company (LLC), you must provide the names of members, attach a list with the names and address of the members of the limited liability company;
    - For a corporation, you must provide the name and title of each corporate officer.
    - Attach the required documentation on an 8.5” x 11” paper.

Part E: Licensure Changes

- For an amended license, choose either a, b, c, or d and complete the appropriate section.
- **For change of licensee, a new application must be completed and signed by the new licensee.**

Part F: Verification

- The application shall be signed by the following:
    - If an individual, the owner
    - If a limited liability company, the head of the limited liability company
    - If a corporation, two of its officers
    - If governmental unit, the head of the governmental department having jurisdiction
- This page must be notarized

OFFICE MECHANICS AND FILING: The original shall be placed in the master file of the activity and maintained there in accordance with the most restrictive retention schedule assigned to this document or other documents contained in the file. The most restrictive retention schedule in the master files is SBH-16327, which requires documents to be kept for six years. Records are then shipped to the Consolidated Storage Center for retention of not less than 24 years before destroying.

Required Documentation

Initial

- ❑ Completed application
- ❑ Proof of ownership of real property on which the facility is located or lease agreement allowing the Licensee to occupy the real property on which the facility is located
- ❑ Verification of Administrator's qualifications
- ❑ Licensing Fee: $75.00 plus $50.00 per satellite facility

Renewal

- ❑ Completed application
- ❑ Licensing Fee: $75.00 plus $50.00 per satellite facility

Amended License

- Change of Location, Change in Facility Name, or Change in Facility Service Type
  - ❑ Completed application

Change of Licensee

- Change in controlling interest
  - ❑ Completed application
  - ❑ Licensing Fee: $75.00 plus $50.00 per satellite facility
- Change in type of legal entity
  - ❑ Completed application
  - ❑ Licensing Fee: $75.00 plus $50.00 per satellite facility

Note: Additional requirements for:

Medication Unit

- ❑ Registration from Bureau of Drug Control
- ❑ Registration from federal Drug Enforcement Administration
- ❑ Certificate of Need

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Part A: Reason for the Application			
❑ **Initial**	❑ **Renewal** **License #_____** **Exp. Date_____** Complete Sections B, C, D, and F	❑ **Amended** **License #_____** **Exp. Date_____** Complete Sections B, E and F	❑**Change of Licensee** **License #_____** **Exp. Date_____** ***New application must be completed and signed by new licensee.**

Part B: Facility Information			
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Do you have an Opioid Treatment Program? ❑ yes ❑ no If yes, please list the narcotics used:			
Contact Person and Correspondence Mailing Address *(Name of the person who can make licensure/operation decisions about the facility and the address where ALL correspondence, including the License, shall be received.)*			
Name:		Title:	
Address:			
City:	State:	Zip:	
Email:			
Telephone Number:		Fax Number:	
Qualified Administrator			
Name:			
Email:			
Telephone Number:		Fax Number:	

Part C: Satellite Facilities			
Location 1	Is this a: ❑ Satellite location ❑ Medication Unit Note: The Facility shall obtain a registration from the Department's Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration for each Medication Unit.		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Location 2	Is this a: ❑ Satellite location ❑ Medication Unit Note: The Facility shall obtain a registration from the Department's Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration for each Medication Unit.		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Location 3	Is this a: ❑ Satellite location ❑ Medication Unit Note: The Facility shall obtain a registration from the Department's Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration for each Medication Unit.		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Location 4	Is this a: ❑ Satellite location ❑ Medication Unit Note: The Facility shall obtain a registration from the Department's Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration for each Medication Unit.		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	

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Part D: Licensee/Owner Information

Renewal and Relocation Applications Only:

❑ By checking this box, I attest that there is no change in ownership from my previous application.

Licensee Name:		
Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	

Ownership Type:

- ❑ Sole Proprietorship
- ❑ Partnership
- ❑ Limited Partnership
- ❑ Corporation
- ❑ Limited Liability (LLC)
- ❑ Government
- ❑ Other_____

Licensee or Owner Documents Required:

1. Secretary of State Documentation, if applicable
   ❑ Attached ❑ Not Applicable
2. If the licensee is a corporation or partnership, attach a list identifying all officers.
   ❑ Attached ❑ Not applicable
3. If the licensee or owner is a corporation or partnership, attach a list with the name, address, and percentage of all owners that possess 5% or more ownership of the company or partnership.
   ❑ Attached ❑ Not applicable
4. If any person or other legal entity can claim liabilities of the licensee or of the facility or service for which this license is requested, attach a list identifying the name, address, percent and type of claim.
   ❑ Attached ❑ Not applicable

Part E: Request for Amended License

1. Amended License
   a. ❑ Change in Facility Name
   b. ❑ Change of Facility Location
   c. ❑ Change in Facility Service Type
   d. ❑ Addition of Satellite Location or Medication Unit

Section 1a: Change in Facility Name:			
New Facility Name:			
Section 1b: Change in Facility Location			
New Facility Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Section 1c: Change in Facility Service Type:			
Opioid Treatment Program		❑ Adding	❑ Removing
Section 1d: Addition of Satellite Location or Medication Unit Note: If adding more than 2, attach an 8” x 11” paper labeled to identify section.			
Location 1	Is this a: ❑ Satellite location ❑ Medication Unit		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	
Location 2	Is this a: ❑ Satellite location ❑ Medication Unit		
Facility Name:			
Physical Address:			
City:	State:	Zip:	County:
Telephone Number:		Fax Number:	

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Part F: Verification

The application shall be signed by the following:

- If an individual, the ***owner(s)***
- If a limited liability company, the ***head of the limited liability company***
- If a corporation, ***two*** of its ***officers***
- If governmental unit, the ***head of the governmental department*** having jurisdiction

I, the undersigned, being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with the standards set forth in South Carolina Regulation 60-93. I understand that noon-compliance with these standards may result in the Department pursuing enforcement actions as provided in Regulation 60-93.

Signature:
Printed Name:
Date:

Signature:
Printed Name:
Date:

Subscribed and sworn to before me this _____day of _____, _____

(Month) (Year)

NOTARY PUBLIC_____

My commission expires: _____ Notary Seal: