Virginia Department of Behavioral Health and Developmental Services

RENEWAL PROVIDER APPLICATION FOR LICENSING

***SECTION 1*: Applicant Renewal Information:** Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization Name:_____License #_____

Mailing Address_____

City:_____ County _____State:_____

Zip:_____ Phone: ( )_____

CEO or CAO:_____ Phone:( )_____

Fax Number: ( )_____Email: _____

**Please review the "licensed as" statement for accuracy in the descriptions of services. If any are inconsistent with the actual service, please note the discrepancy on the license.

***SECTION 2*: Service Renewal Information:** Please list the license numbers you are applying for renewal:

1. _____-____-_____ **9.** _____-____-_____

2. _____-____-_____ **10.** _____-____-_____

3. _____-____-_____ **11.** _____-____-_____

4. _____-____-_____ **12.** _____-____-_____

5. _____-____-_____ **13.** _____-____-_____

6. _____-____-_____ **14.** _____-____-_____

7. _____-____-_____ **15.** _____-____-_____

8. _____-____-_____ **16.** _____-____-_____

***SECTION 3*: Service Close Information:** Please list the license numbers you are choosing **NOT TO RENEW** and are surrendering:

1. _____-____-_____ **4.** _____-____-_____

2. _____-____-_____ **5.** _____-____-_____

3. _____-____-_____ **6.** _____-____-_____

SECTION 4: Service Change Information: PLEASE LIST CHANGES ONLY:

Revised /9/11/2014

1. **Location Name**:_____ License #:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____Phone: ( )_____

Fax Number: _____Location E-mail:_____

Directions:_____

2. **Location Name**:_____ License #:_____# of beds:_____

Address:_____

City:_____ County _____ State:_____ Zip:_____

Location Manager:_____Phone: ( )_____

Fax Number: _____Location Email:_____

Directions:_____

3. **Location Name**:_____ License #:_____# of beds:_____

Address:_____

City:_____County _____ State:_____ Zip:_____

Location Manager:_____ Phone: ( )_____

Fax Number: _____Location Email:_____

Directions: _____

4. **Location Name**:_____ License #:_____# of beds:_____

Address:_____

City:_____County _____ State:_____ Zip:_____

Location Manager:_____ Phone: ( )_____

Fax Number: _____Location Email:_____

Directions: _____

5. **Location Name**:_____ License #:_____# of beds:_____

Address:_____

City:_____County _____ State:_____ Zip:_____

Location Manager:_____ Phone: ( )_____

Fax Number: _____Location Email:_____

Directions: _____

Note: If there are additional locations, please photocopy additional sheets as needed.

SECTION 5. CERTIFICATE OF APPLICATION:

This Certificate of Application is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance, if licensed.

I grant permission to authorized agents of the Department of Behavioral Health and Developmental Services to make necessary investigations into this application or complaints received. I understand that unannounced visits will be made to determine continued compliance with regulations.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

IT IS MY INTENT TO: (a) COMPLY WITH ALL APPLICABLE STATUES AND (b) TO MAINTAIN COMPLIANCE WITH ALL APPLICABLE REGULATIONS

Signature of Applicant: _____ Date:_____

Title:_____

***RENEWAL FEE*:**

Providers of CHILDREN'S RESIDENTIAL SERVICES only must submit with the renewal application a $100.00 renewal fee. The business check or a money order should be made payable to the "Treasurer of Virginia". Personal checks or cash are not accepted

RETURN ADDRESS:

If you have any questions concerning the application, please contact this office at (804) 786-1747.
*Please return this application within **30** days of receipt to:*

The Office of Licensing
Department of Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797
Website: http://www@dbhds.virginia.gov

Please note: Failure to return may delay the renewal of this provider license and services.