DIVISION OF
SUBSTANCE USE
PREVENTION AND RECOVERY

Illinois Department of Human Services

LICENSING AND
CERTIFICATION

SUBSTANCE USE DISORDER SERVICES

APPLICATION FOR INTERVENTION/TREATMENT
LICENSE AND/OR MEDICAID CERTIFICATION

This application is for: ***(check only one)***

☐ **A New License/Medicaid Certification**
☐ **Adding New Services or Medicaid Certification to an Existing License**

SECTION 1: APPLICATION FEE AND MAILING INFORMATION

- A separate application is required for each license/certification.
- An application fee of $200 is required for each license.
- No fee is required for Medicaid certification or to add services or certification to a currently licensed facility.
- No fee is required from any unit of local, state or federal government.
- The application fee is non-refundable and must be submitted with the application for each license.
- The application fee shall be made by check or money order and payable to the Illinois Department of Human Services.
- The complete application and the fee, if applicable, should be mailed to:

Illinois Department of Human Services
Division of Substance Use Prevention and Recovery (SUPR)
Licensing and Certification
401 South Clinton Street, Second Floor
Chicago, Illinois 60607-3800

SECTION 2: CORPORATION INFORMATION

Complete Legal Name of the Corporation: _____

Attachment 1: Complete and attach and Internal Revenue Service (IRS) form W-9 and a letter documenting that you are registered with the IRS. Please note that the complete corporation legal name must match the legal name indicated on your IRS Form W-9.

Doing Business as (d.b.a.) *(If applicable)*: _____

Legal Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____ County: _____

Fax: (_____) _____ E-mail Address: _____

IMPORTANT NOTICE: *The Illinois Department of Human Services is requesting voluntary disclosure of information that is necessary to accomplish the statutory purposes as provided in Ill. Rev. Stat., ch. 20 ILCS 301 and 77 Ill. Adm. Code 2060. Non-disclosure of this information may prevent this form from being processed. Form approved by State Forms Management Center. The Department does not discriminate in its activities in compliance with the Americans with Disabilities Act of 1990 and with the Civil Rights Act. Should you need assistance regarding this application, please contact 312-814-5814 or 312-814-6357.*

PLEASE SPECIFY:

Government Entity: ☐ Federal ☐ State ☐ County ☐ Local

☐ Corporation *(Specify Type)* - ☐ For-Profit ☐ Not-for-Profit

☐ Partnership ☐ Association ☐ Sole Proprietor ☐ LLC ☐ Other

☐ Federally Qualified Health Center (FQHC)

☐ Religious or Charitable Organization (If so, provide proof of registration as **Attachment 18**) Instructions located at http://www.ag.state.il.us/charities/co-1instructions.pdf

FEIN: _____

Attachment 2: Corporations or LLC's must attach documentation from the Illinois Secretary of State that the above entity is authorized to do business in Illinois and is in good standing. As applicable, attach a copy of articles of incorporation, bylaws and/or letter of agreement of partnership. Sole proprietors must submit a copy of registration as a sole proprietor from the Office of the County Clerk.

Attachment 3: Does this organization currently receive funding from SUPR? ☐ Yes ☐ No

If yes, has the Bureau of Business and Fiscal Operations approved funding for the proposed new location and/or service? ☐ Yes ☐ No

If yes, attach approval letter or e-mail as Attachment 3.

If no, please note that the approval of a new facility license or new service does not guarantee funding for that location or service.

SECTION 3: FACILITY INFORMATION

SPECIFY THE ADDRESS WHERE SERVICES WILL BE DELIVERED

Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____ County: _____

Fax: (_____) _____ E-mail Address: _____

IF THE REQUEST IS FOR NEW SERVICES OR MEDICAID CERTIFICATION FOR AN EXISTING LICENSE AT THE ABOVE REFERENCED FACILITY LOCATION, SPECIFY THE FOLLOWING:

Current License Number for this Facility: _____

Current Medicaid Certification Number for this Facility: _____

SECTION 4: AUTHORIZED ORGANIZATION REPRESENTATIVE

SPECIFY IDENTIFYING INFORMATION FOR THE INDIVIDUAL IN WHOM AUTHORITY IS VESTED FOR THE MANAGEMENT, CONTROL AND OPERATION OF ALL SERVICES AT THE FACILITY AND FOR COMMUNICATION WITH THE DEPARTMENT REGARDING THE STATUS OF THE ORGANIZATION'S LICENSES AT THAT FACILITY.

Name: _____

Address: _____

Suite, Floor, Room, P.O. Box No.: _____

City: _____ State: _____ Zip Code: _____

Title: _____ Telephone: (_____) _____

SECTION 5: MANAGEMENT

Attachment 4: Complete and attach a Schedule A – Ownership Disclosure, for each owner or controlling party if the applicant is a FOR-PROFIT organization (unless an owner or controlling party owns less than 5 percent stock in the organization).

Attachment 5: If the applicant is a NOT-FOR-PROFIT organization, there must be a Board of Directors. Attach a listing of the names of all board members and the name, address and phone number of the Chairman of the Board.

Attachment 6: Attach a current organization chart that indicates the management and operational structure of the organization.

SECTION 6: MEDICAL DIRECTOR, PHYSICIAN AND PHYSICIAN EXTENDERS – APPLICABLE FOR TREATMENT LICENSES

Attachment 7: Complete and attach a Schedule E for the facility's Medical Director and one for each physician or physician extender who will provide substance use disorder treatment services. Each schedule must contain the specimen signature and initials of the physician or physician extender who will review the assessment, verify medical necessity, diagnosis, initial placement in treatment, treatment plans and continued stay of reviews. This specimen signature and initials will be used during inspections and/or clinical patient record reviews to verify authorization.

SECTION 7: PROFESSIONAL STAFF

Attachment 8: Complete and attach a Schedule L for each professional staff who will provide clinical and/or intervention services as defined in 77 Illinois Administrative Code, Part 2060.309 or who will provide Recovery Home services as defined in Part 2060.509(g)(h).

SECTION 8: FACILITY REQUIREMENTS

Attachment 9: Complete and attach a Schedule C – Statement of Compliance and Life Safety Inspection Report. This schedule must be completed and signed by an architect for the facility specified in this application. If adverse findings are specified on this schedule, do not submit the application until all findings have been corrected. Applicants must also provide documented proof of compliance with all applicable zoning and local building ordinances.

Attachment 10: Accreditation Status – If the facility has accreditation for substance use disorder treatment services, specify the type and include the most recent compliance survey results:

JCAHO – Joint Commission on the Accreditation of Healthcare Organizations: ☐ Yes ☐ No

CARF – Commission on Accreditation of Rehabilitation Facilities: ☐ Yes ☐ No

COA – Council on Accreditation: ☐ Yes ☐ No

AAAHC – Accreditation Association for Ambulatory Health Care: ☐ Yes ☐ No

Other: *(Please specify)* _____

Please specify any foreign language and/or hearing-impaired services offered at the facility:

_____

_____

_____

SECTION 9: LEVELS OF CARE, TYPES OF SERVICES AND TARGETED POPULATION

Please specify the levels of care, the population, and as applicable, the number of beds that will be provided at the facility or those services which will be added to an existing license.

SUBSTANCE USE DISORDER TREATMENT

Levels of Care	Specify No. of Beds	Population	
☐ Level 1 – Outpatient		☐ Adult	☐ Adolescent
☐ Level 2 – Intensive Outpatient		☐ Adult	☐ Adolescent
☐ Level 2.5 – Partial Hospitalization		☐ Adult	☐ Adolescent
☐ Level 3.1 – Residential Extended Care		☐ Adult	☐ Adolescent
☐ Level 3.5 – Clinically Managed Medium to High Intensity Residential		☐ Adult	☐ Adolescent
☐ Level 4 – Medically Managed Intensive Inpatient		☐ Adult	☐ Adolescent
☐ Level 3.2 – Withdrawal Management – Clinically Managed		☐ Adult	☐ Adolescent
☐ Level 3.7 – Withdrawal Management – Medically Monitored		☐ Adult	☐ Adolescent
☐ Level 4 – Withdrawal Management – Medically Managed		☐ Adult	☐ Adolescent
Methadone used as an adjunct to any of the treatment levels of care specified above.		☐ Yes	☐ No

SUBSTANCE USE DISORDER INTERVENTION

☐ DUI Evaluation ☐ DUI Risk Education ☐ Designated Program

☐ Recovery Home Please specify the number of beds: _____

For DUI Risk Education and DUI Evaluation ONLY. Please provide the payment address for reimbursement from the Drunk and Drugged Driving Prevention Fund (DDDPF).

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SECTION 10: MEDICAID CERTIFICATION

IF APPLICABLE, SPECIFY CURRENT SUBSTANCE USE DISORDER TREATMENT LICENSE NUMBER OR ILLINOIS DEPARTMENT OF PUBLIC HEALTH LICENSE NUMBER. _____

IF APPLICABLE, INCLUDE A COPY OF THE MEDICAID CERTIFICATION ISSUED BY THE IDHS/DIVISION OF MENTAL HEALTH.

SPECIFY THE LEVELS OF CARE FOR WHICH YOU ARE REQUESTING MEDICAID CERTIFICATION.

Levels of Care	Specify No. of Beds	Population	
☐ Level 1 – Outpatient		☐ Adult	☐ Adolescent
☐ Level 2 – Intensive Outpatient		☐ Adult	☐ Adolescent
☐ Level 2.5 – Partial Hospitalization		☐ Adult	☐ Adolescent
☐ Level 3.5 – Day Treatment Only, 16 Beds or Less		☐ Adult	☐ Adolescent
☐ Level 3.5 – Psychiatric Residential Treatment Facility - PRTF		☐ Adult	☐ Adolescent
☐ Level 3.7 – Medically Monitored Withdrawal Management, 16 Beds or Less		☐ Adult	☐ Adolescent
Methadone used as an adjunct to any of the treatment levels of care specified above.		☐ Yes	☐ No

SECTION 11: APPLICATION REVIEW CRITERIA

Prior to acceptance of the application, the Department will seek to verify that the capability and integrity of ownership and/or professional staff is sufficient to assure that the applicant can conduct services with reasonable judgement, skill and safety and in accordance with all relevant specifications contained in 77 Illinois Administrative Code, Parts 2060 and 2090. In making this determination, the Department may consider, but is not limited to, the following:

1. the accuracy of attachments and information submitted with and contained in the application;
2. prior criminal conduct by ownership or professional staff;
3. prior violations of Part 2060 or any other Department rule by the organization or by personnel either as current owners or employees of the applicant organization or as employees of any other organization that has held or holds a license from the Department.

Include with this application, as **Attachment 11** a narrative description of the following:

1. evidence of the need within the community for the type of service to be provided;
2. description of the organization that will be operating the services;
3. fiscal solvency of the organization;
4. description and floor plan of the physical facilities to be utilized by the organization and any rationale for the delivery of offsite services;
5. description of services and the population that will be served;
6. projection of the total number of the individuals to be served each month, the average anticipated length of services and the estimated cost of services; and
7. schedule of the specific days, times and places that services will be provided.

Additionally, the Department will schedule an interview with the applicant that may be in person or by telephone. The purpose of this interview is to discuss the attached narrative and to determine the practical application within the organization of all applicable requirements contained in Administrative Rules, Parts 2060 and 2090. Specifically, all applicants should be prepared to discuss applicable policy and procedure requirements in Part 2060, Subpart C, and how they are communicated to staff who implement them daily.

As part of the interview:

- Applicants for new treatment licenses/services and/or Medicaid certification should be prepared to discuss all substance use disorder treatment medical and clinical standards contained Part 2060, Subpart D. As applicable, include with this application as **Attachment 12,** all linkage agreements with licensed substance use disorder treatment providers for any treatment service not offered by the applicant. As applicable, include as **Attachment 17**, a copy of the Medicaid Certification issued by the IDHS/Division of Mental Health.
- Applicants for a DUI Evaluation or Risk Education intervention license should be prepared to discuss and demonstrate a fundamental and practical understanding of the intervention requirements mandated in Part 2060, Subpart E, Sections 2060.503 and 2060.505. Also, include with this application as **Attachment 13**, any letters of agreement, as applicable, with Circuit Courts of Venue who will refer offenders for services and be recipients of Evaluation or Risk Education documents. This attachment should also address how recommendations for modifications to risk classifications and interventions will be communicated to the applicable court. Please note: if your organization only intends to provide DUI services for the Illinois Secretary of State, **Attachment 13** is not required.
- Applicants for Recovery Home licenses should be prepared to describe the structure and content of weekly peer led or community gatherings, the admission policy and targeted population. Include as **Attachment 14**, copies of all linkage agreements with substance use disorder treatment providers and a description of the referral network that will be utilized by residents for any necessary medical, behavioral health, vocational or employment resources. Include as **Attachment 15**, a copy of a budget which specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve equivalent to two months of operating expenses. Include as **Attachment 16**, documentation of fire, hazard, liability and other insurance coverages appropriate to the administration of a Recovery Home and, if applicable, documentation of compliance with zoning requirements.

SECTION 12: APPLICANT AFFIRMATION

The application must be signed by: at least two corporate officers vested with authority to act on behalf of the corporation, or; if applicant is a partnership or association, by all partners or associates; and by the Chairman of the Board of Directors. Use additional pages as necessary.

By signature below applicant hereby certifies and affirms that there are no current citations for local ordinance violations; that any previous citations have been corrected to the satisfaction of all applicable authorities; and that the premises are in compliance with all applicable state and local codes.

By signature below applicant acknowledges the right of the Department to verify the data supplied in this license application and consents to such inquiries as might be required. It is understood that, confidential information provided in this application or obtained during the course of any inquiry will be used only for the purposes collected and be maintained confidential by the Department, and not re-released except as allowed by law. Any information provided in the application which the applicant believes to be confidential/proprietary information or trade secrets should be clearly marked as such or applicant waives its right to claim confidentiality regarding such.

By signature below applicant certifies and affirms that none of the applicant's owners, operators or managers have had a federal registration to distribute or dispense methadone, suspended or revoked or had any governmental license relating to the operation of the facility suspended or revoked, or been convicted within the previous two (2) years in any court of law of operating a motor vehicle while under the influence of alcohol or any drug.

By signature below applicant certifies and affirms that the content of this application and attached schedules, affirmations and materials are true and correct. By signature below applicant certifies and affirms that it is in compliance with all applicable provisions of state and federal constitutions, laws, regulations, court rules and judicial orders, including but not limited to:

a) Title 77, Illinois Administrative Codes, Part 2060 and Part 2090;
b) The Illinois Human Rights Act, [775 ILCS 5];
c) The Americans with Disabilities Act of 1990, (42 USC 12101) and the regulations and guidelines;
d) The Environmental Barriers Act [410 ILCS 25] and The Illinois Accessibility Code (71 Ill. Adm. Code 400);
e) The Age Discrimination Act of 1975; and
f) The 1991 Civil Rights Act.

Signature *Date*	*Signature* *Date*
Name (Type/Print)	*Name (Type/Print)*
Date	*Date*

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____ DAY OF _____, _____

(Seal)

_____
NOTARY PUBLIC/STATE OF ILLINOIS

APPLICATION CHECKLIST

Please keep the application and all schedules in order. Attach the schedules at the back of the application and insert an index for reference. Check, as applicable, that the application contains the following:

- ☐ Check or Money Order, as applicable, for the license fee and the original complete application
- ☐ Attachment 1: IRS form W-9 and the letter from the IRS.
- ☐ Attachment 2: Documentation from the Illinois Secretary of State or County Clerk, as applicable.
- ☐ Attachment 3: If applicable, a copy of the approval letter or e-mail from the SUPR Bureau of Business and Fiscal Operations for funding for the new location or service.
- ☐ Attachment 4: Schedule A.
- ☐ Attachment 5: If applicable, Board of Directors information.
- ☐ Attachment 6: Organization Chart.
- ☐ Attachment 7: Schedule E.
- ☐ Attachment 8: Schedule(s) L.
- ☐ Attachment 9: Schedule C and documented proof of compliance with all applicable zoning and local building ordinances.
- ☐ Attachment 10: If applicable, the most recent accreditation survey.
- ☐ Attachment 11: Narrative description.
- ☐ Attachment 12: For treatment services, as applicable, copies of linkage agreements.
- ☐ Attachment 13: If applicable, for DUI Evaluation and Risk Education only, copies of letters of agreement with Circuit Courts of Venue.
- ☐ Attachment 14: For Recovery Homes only, copies of linkage agreements.
- ☐ Attachment 15: For Recovery Homes only, copy of an operating budget.
- ☐ Attachment 16: For Recovery Homes only, documentation of fire, hazard, liability and other insurance coverages appropriate to the administration of a Recovery Home.
- ☐ Attachment 17: If applicable, a copy of the Medicaid Certification issued by the IDHS, Division of Mental Health.
- ☐ Attachment 18: If, applicable, proof of registration as a religious or charitable organization.