New Jersey Department of Health
Office of Licensing – Mental Health and Addiction Services
P.O. Box 358
Trenton, NJ 08625-0358

APPLICATION FOR AMBULATORY MENTAL HEALTH PROGRAMS

Date of Application: | Date Application Received by Department of Health:

Official Name of Agency Fed Tax ID #	Official Site/Program Name Fed. Tax ID # (If diff. from Agency)
	Type of Ownership Non-Profit ☐ For Profit ☐
Headquarters Site Address	Site Address County
City State Zip Code	City State Zip Code
Telephone Number Fax Number	Telephone Number | Fax Number
Headquarters Mailing Address	Name of Facility Administrator/Director/CEO
City State Zip Code	Title Email Address:
Name of Facility Administrator/Director/CEO	Name of Contact Person
Title of Contact Person	Telephone Number ( ) | Email Address:
Telephone Number E mail Address	Name of Emergency Contact Person
Web page Address	Emergency Telephone Number ( ) | Email Address

Accredited Yes ☐No ☐
If yes, please list the information below:

Name of Organization Granting license and/or accreditation: Effective Dates

1.
2.
3.
4.

Please use attach additional pages if necessary

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Parent Organization Name: Federal Tax ID #:	
City State Zip Code	Name Administrator/Director/CEO
Telephone Number Fax Number	Email Address:

Does the owner/entity currently own other agencies in New Jersey? Yes ☐No ☐
If yes, please enter information on all agencies below:

Agency Name:	Telephone Number
1.	
2.	
3.	
4.	

Please use attach additional pages if necessary

Does the Agency have any Department of Human Services or other Department of Health licensed programs? Yes ☐No ☐
If yes, please enter information on all agencies below:

Program Name:	License Number
1.	
2.	
3.	
4.	

Please use attach additional pages if necessary

New Program Site Information

Anticipated Start Date of New Program:	
Program Element Code: DMHAS “Affiliation Agreement” Yes ☐ No ☐ *A blank Affiliation Agreement is part of the application. Only one Agreement is needed per Agency.*	DMHAS Contract Yes ☐ No ☐ DMHAS Fee for Service Yes ☐ No ☐ DCF/DCBHS Contract Yes ☐ No ☐ Medicaid Certified Yes ☐ No ☐
Certificate of Occupancy is included: ☐	Fire Inspection Certificate is included: ☐
Program Days:	Program Hours:
Program Director/Coordinator/Supervisor: Name:	Title:
Telephone Number:	Email Address:

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Degrees and Professional Licenses:

Service Population Demographics (Check all that apply)

Age Groups	Service Groups	Gender
☐ Under 14	☐ Mental Health	_____% Females
☐ 14-17	☐ DD	_____% Males
☐ 18-20	☐ Substance Abuse	
☐ 21-64	☐ Other: _____	
☐ 65+		

Psychiatrist and Advanced Practice Nurse Roster:

Full Name/Title	Board Status, if applicable (Certified, Eligible)	Hours Per Week	CDS and DEA Certification Numbers and Effective Dates

Roster of All Other Staff (Use additional forms if necessary)

Last Name & First Name Initial	Job Title	Hours per Week	Degree(s)	Date of Hire, Promotion, or Transfer into current position	License Numbers

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Documents Checklist

Instructions:

- Enclose a copy of each item listed below.

☐ Certificate of Incorporation/Charter

☐ Synopsis of the applicant agency's service history including services provided at any U.S. location

☐ Applicant Agency Mission Statement

☐ Agency brochures and program descriptions

☐ Confidentiality Policies and Notice of Privacy Practices

☐ QA Plan

☐ Client Rights & Grievance procedure given to consumers

☐ Policies & Procedures required by the regulations (see asterisked items in the crosswalks; do not submit additional policies and procedures unless requested)

☐ Medication counseling and education policies/procedures

☐ Psychiatric advance directives policies/procedures

☐ Behavioral management policies/procedures

☐ Program Job descriptions

☐ All forms used in the clinical record to meet the documentation requirements in the regulations (e.g. intake, comprehensive assessment, psychiatric evaluation, treatment plan, medication counseling form, termination summary)

☐ **Licensing Application fee (for initial applicants only)**

Please note that for each new site, a Certificates of Occupancy, fire inspection certificate by the municipality and a local health department sanitation inspection certificate (for sites with kitchens where meals are prepared for consumers) will be required prior to licensure.

Cultural/Linguistic Accessibility

Identify the demographic composition of your Service Area (from recent census data, local planning documents, statements of need, etc.) specific to ethnicity, race and primary languages spoken.

Identify the staff composition of your agency (ethnicity, race, language capabilities of all staff) in relation to the demographic composition of Service Area.

Family Involvement

Does the Agency's Board of Directors gather information on the operation of the agency from families of clients served by the agency on a regular basis?

Yes ☐ No ☐

If Yes, how?

Are families asked to complete satisfaction surveys as part of the agency's quality assurance process?

Yes ☐ No ☐

Are findings shared with family organizations? Yes ☐ No ☐

Does the agency have a family advisory board or committee?

Yes ☐ No ☐

If yes, how frequently do they meet with executive staff?

Central Registry of Offenders Against Individuals with Developmental Disabilities Requirement

Does the agency have a policy and procedure that supports compliance with N.J.A.C. 10:44D regarding the Central Registry requirements

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Yes ☐ No ☐

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Wellness and Recovery/Illness Management and Recovery

Has your Agency received formal Wellness and Recovery training?

Yes ☐ No ☐

If yes, please identify the trainer, staff trained and describe how the Wellness and Recovery principles are integrated into your agency's overall treatment approach?

Please describe how closely your agency's mission, vision, job descriptions and performance evaluations for practitioners and clinical supervisors demonstrate evidence of Wellness and Recovery principles and constructs.

Has your agency received Illness Management and Recovery (IMR) training and consultation?

Yes ☐ No ☐

If yes, who oversees the IMR implementation, including taking responsibility for updating all appropriate mission, vision, job description, and performance evaluations?

Has your organization identified one key voluntary IMR Clinical Supervisor? (e.g., IMR Specialist). If yes, please identify the IMR Clinical Supervisor/Specialist.

Have staff/clinicians received training to develop core competencies in Motivational Interviewing, Cognitive Behavioral Therapy and Educational Strategies?

If your agency has received IMR training, please identify the IMR staff that are trained, the number of clinicians providing IMR and number of consumers receiving IMR services.

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Attestation [Form 5.1]

Instructions:

- An authorized official must sign and date the form.
- Enter the information on the agency contact. This person is usually the one who supervised the application process and/or is the designated Chief Executive.

The Applicant Certifies:

1. That all data supplied in this application and attachments are true and correct, to the best of his/her knowledge and belief that willful misrepresentations of these facts may make the applicant subject to civil penalties;

2. that the application has been duly authorized by the governing body of the applicant. The program as proposed will be adjusted as necessary to address the specific needs of the individuals as they are identified. Adjustments will be made only with the approval of DMHAS or DCBHS; and

3. that the facility has been and will be operated in accordance with the applicable licensing requirements.

Agency Contact Person

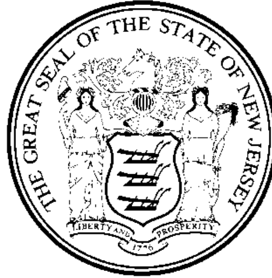
Name: _____

Title: _____

Telephone: _____ ext. _____

Signature and Title of Authorized Official **Date**

Affiliation Agreement



State of New Jersey

Mental Health Program Licensure Affiliation Agreement
Between
Department of Health – Division of Mental Health and Addiction Services
And

_____
Provider

WHEREAS, the Community Mental Health Services Act, N.J.S.A. 30:9A-1 et seq. ("the Act"), provides for the development of preventive treatment and transitional services for mental health clients through the improvement and expansion of community mental health programs in designated areas in New Jersey;

WHEREAS, the Department has promulgated regulations which implement the Act and which establish minimum programmatic standards for the provision of community mental health services (N.J.A.C. 10:37-10 et seq.);WHEREAS, the Department and _____ ("the Provider") desire to enter into this affiliation agreement in order to ensure the delivery of high quality mental health services to consumers in the community, in accordance with the Act and its implementing regulations;

The Department and the Provider hereby agree to the following terms:

1. The Provider shall comply with all applicable Federal and State laws and policy, and all implementing regulations, including but not limited to N.J.A.C. 10:190-1 and standards incorporated by reference.

2. The Provider shall keep such records as are necessary to fully disclose the extent of services provided to consumers and shall comply with all confidentiality requirements in accordance with N.J.S.A. 30:4-24.3.
3. The Provider shall conspicuously post license(s) issued under N.J.A.C. 10:190-1 at each licensed program and site, and shall comply with all terms of the license.
4. The Provider shall notify the Office Of Licensing – Mental Health Licensing of any and all major changes in staffing or organization.
5. The Provider shall notify the Office Of Licensing – Mental Health Licensing at least 60 days prior to closing a mental health program.
6. The Department agrees to issue a community mental health program license to the Provider upon its determination that the mental health program has satisfied the requirements of N.J.A.C. 10:190-1 et seq.
7. Nothing in the Act, implementing regulations, or this Agreement shall be construed as granting state agency status to the Provider.
8. This Agreement may be revised or modified by written amendment when both parties agree to such amendment.

IN WITNESS WHEREOF, the parties intend to be legally bound by this Agreement and, for this purpose, have authorized their respective officers to duly execute this Agreement:

______________________________	______________________________
Provider's Signature	Department of Health Signature
______________________________	______________________________
Print Name & Title	Print Name & Title
______________________________	______________________________
Date	Date

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Program Element Codes

Instructions:

- Use this document to enter the “Program Element Code” data on the “Application for New Satellite Program” form.
  - For example, if you are applying for licensure of a new Outpatient program site, enter “04” in the space provided.

OUTPATIENT SERVICES [10:37E] ENTER CODE: 04
Services provided to clients who possess a psychiatric diagnosis, including clients who are seriously and persistently mentally ill but excluding substance abuse and developmental disability unless accompanied by treatable symptoms of mental illness. Periodic therapy, counseling and supportive services are generally provided at the provider agency for relatively brief sessions (between 30 minutes and 2 hours).

ADULT PARTIAL CARE SERVICES [10:37F] ENTER CODE: 05
Comprehensive, structured, non-residential health services provided to seriously mentally ill adult clients in a day program setting to maximize client’s independence and community living skills. Partial Care programs provide or arrange services necessary to meet the comprehensive needs of individual clients.

PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT (PACT) [10:37J] ENTER CODE: 10
Comprehensive, integrated rehabilitation, treatment and support services to those individuals most challenged by the need to cope with serious and persistent mental illness, as evidenced by repeated hospitalizations and to those individuals identified as at serious risk for psychiatric hospitalization. PACT, provided in vivo by a multi-disciplinary service delivery team, is the most intensive program element in the ambulatory continuum of community mental health care. Services to an individual may vary in type and intensity, but treatment has no predetermined end point.

INTENSIVE FAMILY SUPPORT SERVICES (IFSS) [10:37I] ENTER CODE: 12
Family driven supportive activities designed to improve the overall functioning and quality of life of families with a mentally ill relative.