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

APPLICATION FOR NEW OR AMENDED RESIDENTIAL AND OUTPATIENT SUBSTANCE USE DISORDER TREATMENT FACILITY LICENSE

LICENSURE PROCESS AND REQUIREMENTS

General

Licensure by the Department Health (DOH), Office of Licensing (OOL) is mandatory **PRIOR TO** commencement of new or expanded services. To be licensed as an operator of a substance use disorder treatment program in New Jersey, all of the applicable licensing requirements for that service must be met. This includes both operational and physical plant requirements. To obtain the licensing standards for the proposed service and/or additional information regarding the licensure process, please call: 609-292-6587.

Functional Review

The Department highly recommends that prospective applicants contact OOL, Technical Assistance Unit to register for a functional review. The OOL conducts monthly functional reviews to discuss physical plant requirements, policies and procedures, licensing protocols, and applicable rules and regulations. It is also highly recommended that this functional review occur prior to the submission of the application for licensure. To obtain information about or to register for a functional review, contact the Office of Licensing at: 609-292-6587.

Application Filing

One original and one copy of a complete licensure application which includes documents as listed in "Required Application Documents," OOL-1.1 shall be submitted to the Department of Health, Office of Licensing, PO Box 358, Trenton, NJ 08625-0358. A schedule of fees for licensure and inspection is included below. The licensing/inspection fee shall be in the form of a **certified check or money order** made payable to "Treasurer, State of New Jersey."

Type of Facility	New Application and Initial Inspection Fee	Renewal Fee	Add Beds or Services	Relocation or Reduce Services	Transfer of Ownership Interest	Biennial Inspection Fee
Residential Substance Abuse Treatment Facility	$500 Application + $500 Inspection Fee = $1,000 + $3 per bed	$500 + $3 per bed	$500 + $3 per bed	$250	$1,500	$500
Outpatient Substance Abuse Treatment Facility	$1,750 Application + $300 Inspection Fee = $2,050	$750	0	$250	$1,500	$300

Track Record Requirements

Track record reports from out-of-state agencies responsible for licensing these substance use disorder treatment programs must be submitted WITH YOUR LICENSE APPLICATION. Each out-of-state track record report must indicate the history of compliance with standards in the state for the 12 months preceding application submission, as well as a description of any non-compliance, penalties imposed, duration of non-compliance and corrective actions taken.

Please be advised that in making a determination as to the applicant's capacity to operate a substance use disorder treatment program, the Department will consider the applicant's prior operating history, both in New Jersey and in

other states. Any evidence of licensure violations representing a serious risk of harm to clients, or any record of criminal convictions representing a risk of harm to the safety or welfare of patients may result in denial of the applicant's application for licensure. All substance use disorder treatment programs (residential substance abuse treatment facilities as defined in N.J.A.C.10:161A or Outpatient substance use disorder treatment facilities defined in N.J.A.C.10:161B) owned operated or managed by the applicant and any principals of the applicant entity which are similar or related to the service which is the subject of the application must be disclosed. The license application will be returned if all required out-of-state track record reports are not provided at the time the license application is filed

New Agencies and Amended Application with New Modality

The OOL Technical Assistance Unit shall process licensure applications for agencies which are not currently licensed to provide substance use disorder treatment in New Jersey. In addition, the OOL Technical Assistance Unit shall process amended licensure applications when a new modality is requested by agencies currently licensed to provide substance use disorder treatment in New Jersey. The operational survey shall consist of review and approval of documents as required by form OOL-1.1. Approximately sixty (60) days prior to licensure, the TAU will contact the agency to request the additional information listed in the "Physical Plant Documentation Checklist," OOL-1.3, to initiate the physical plant survey.

ISSUANCE OF LICENSE

A license will be issued by the Department of Health, Office of Licensing upon compliance with all regulatory requirements based on the operational survey and physical plant survey. Once issued, a license shall not be assignable or transferable, and shall be **immediately void** if the program ceases to operate, relocates, or its ownership changes. You **MAY NOT** proceed with initiation of new or expanded services until you have received a license from the Department of Health, Office of Licensing.

RELOCATION, OWNERSHIP (Direct or indirect) CHANGE, or MERGER

One hundred and twenty (120) days prior to the planned change the licensee shall contact the Department of Health, Office of Licensing (OOL) in writing of the anticipated date of the change. The letter should include a dated copy of the Board minutes indicating that the change has been approved (if applicable) and the date of the anticipated change.

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IMPORTANT: Complete and forward one (1) original and one (1) copy to the above address. Please retain a copy for your records.

FOR STATE USE ONLY

Team	☐Approval ☐Denial	Amount Received License Application Fee $ _____ Biennial Inspection Fee $ _____ TOTAL $ _____
Facility License No.	Date Received ____ / ____ / ____	
Reviewer Signature		Date

Type of Application

☐ New Facility - CN Exempt (N.J.S.A. 26:2H-7a)
☐ Amendment
Facility Lic. # _____

Type of Amendment / Number of Beds / OP Services

☐ Bed/Service Addition ____ ____
☐ Bed/Service Reduction ____ ____
☐ Transfer of Ownership (Licensed facilities as provided for at N.J.S.A. 26:2H-7a and N.J.A.C. 8:33-3.3(b) only)
☐ Relocation – **Indicate PREVIOUS and NEW ADDRESS**
☐ Change in Name of Operating Entity
☐ Change in Name of Facility

Fed. Tax ID # (If diff. from Operating Entity)_____ ***Official Name of Facility/Program***	**Fed Tax ID #** _____ **Operating Entity/Operator***
Site Address County	Street Address
City State Zip Code	City State Zip Code
Telephone Number **( )**	Fax Number **( )**
	Telephone Number **( )** _____
Name and email address of Facility Administrator/Director/CEO	Name of Management Company, If Applicable (Submit copy of management agreement.)
Title Email Address:	Address
Name of Contact Person	City State Zip Code
Telephone Number ( )	Email Address:
	Telephone Number ( ) Email Address
Name of Emergency Contact Person	Name of Management Company Contact Person
Emergency Telephone Number ( ) Email Address	Title

** The official name of facility and operating entity will appear on the license. Please provide complete and accurate information. Please complete the application as to the name, address and telephone number for both the facility and operator even when the information is the same. As used in this application, "operator" or "operating entity" refers to the person or entity which is the holder of the facility license (i.e., licensee) and which has the ultimate responsibility for the provision of health care services.*

APPLICATION FOR NEW OR AMENDED LICENSE

Name of Facility/Program**:** **Fed. Tax ID #**_____

SECTION I - INPATIENT FACILITIES

Beds and Services	**New Facility Proposed Capacity/ Services**	**Current Licensed Capacity/ Services**	**Total Change (+) or (-)**	**Revised Capacity/ Services**	**Co-Occurring Services (NJAC 10:161A 10.4)**
Hospital-Based –DETOX					
- Hosp. Based Detox. Adult					Yes [ ] No [ ]
- Hosp. Based Detox. Adult Female					Yes [ ] No [ ]
- Hosp. Based Detox. Adult Male					Yes [ ] No [ ]
Residential Substance Abuse Treatment Beds					
- Extended Care Adult Female					Yes [ ] No [ ]
- Extended Care Adult Male					Yes [ ] No [ ]
- Extended Care Adult					Yes [ ] No [ ]
- Halfway House Adult					Yes [ ] No [ ]
- Halfway House Adult Female					Yes [ ] No [ ]
- Halfway House Adult Male					Yes [ ] No [ ]
- Long Term Adult					Yes [ ] No [ ]
- Long-Term Adult Female					Yes [ ] No [ ]
- Long-Term Adult Male					Yes [ ] No [ ]
- Short-Term Adult					Yes [ ] No [ ]
- Short-Term Adult Female					Yes [ ] No [ ]
- Short-Term Adult Male					Yes [ ] No [ ]
- Non-Hosp. Based Detox. Adult					Yes [ ] No [ ]
- Non-Hosp. Based Detox. Adult Female					Yes [ ] No [ ]
- Non-Hosp. Based Detox. Adult Male					Yes [ ] No [ ]

SECTION II OUTPATIENT CARE FACILITY

Services	**Currently Licensed Services (Check all that apply)** **Adult** **Adolescent**	**New/Amended Proposed Services (Check all that apply)** **Adult** **Adolescent**	**New Facility Proposed Capacity/ Services**
Outpatient			
Intensive Outpatient			
Partial Care			
OTP/ Methadone & Buprenorphine			
Outpatient Detox			
Co-Occurring			

Name of Facility/Program**:** **Fed. Tax ID #** _____

SECTION III - OPERATING ENTITY

Type of Operating Entity

☐Sole Proprietorship ☐Limited Liability Company*
☐Government Agency*** ☐Limited Partnership*****
☐Professional Association ☐General Partnership*
☐Corporation - For Profit ****** ☐Corporation - Nonprofit ******

***Attach list of the names and percentage of holding/interest of all partners**
****Attach list of directors/trustees which includes the names and addresses of board of directors"**

NOTE: If the corporate entity is a wholly-owned subsidiary, please identify the parent corporation:

_____

****Government Agency STATE [ ] COUNTY [ ] CITY [ ] TOWNSHIP [ ] NOT APPLICABLE [ ]**

Please indicate your accreditation:
JCAHO ☐ CARF ☐ C.O.A. ☐ NONE ☐ OTHER ☐ _____

Name and Title of Individual or Current Registered Agent Upon Whom Orders May be Served (Must be NJ Resident)

Residence Address City State Zip Code

Name of Facility/Program**:** **Fed. Tax ID #**_____

SECTION III - OPERATING ENTITY, CONTINUED

PRINCIPALS IN OPERATING ENTITY

Attach a list of the names and addresses of partners/stockholders and identify 100% of the ownership, except that for publicly held corporations, identify each principal who has a 10% or greater interest in the corporation. Applicants for transfer of ownership shall provide information for the PROPOSED operator.

1. Have any of the principals/owners of the operating entity ever applied, directly or indirectly, for health care facility approval in New Jersey, or any other state, which was denied or revoked?

   ☐Yes ☐No

   If Yes, indicate whom and give details (attach additional sheets if necessary):

2. Do any of the principals of the operating entity have an ownership, operational or management interest in any other licensed health care facility in New Jersey, or any other state?

   ☐Yes ☐No

   If Yes, explain the nature of the interest and give name and address of each facility:

3. Have any principals of the operating entity ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?

   ☐Yes ☐No

   If Yes, explain in detail (attach additional sheets if necessary):

4. Have any principals of the operating entity ever been indicted for or convicted of a felony crime?

   ☐Yes ☐No

   If Yes, explain in detail (attach additional sheets if necessary):

5. A. Do any of the principals of the operating entity have an ownership, operational or management interest in any housing, lodging, or concierge services that will be provided in conjunction with the proposed service? ☐Yes ☐No
   If Yes, explain in detail (attach additional sheets if necessary):

   B. Will any of these services be provided through a consultant agreement or through another source? ☐Yes ☐No
   If Yes, explain in detail (attach additional sheets if necessary):

Name of Facility/Program**:** **Fed. Tax ID #**_____

AFFILIATED HEALTH CARE FACILITIES

Identify the name, address and Medicare Provider Number of all health care facilities, both in New Jersey and in any other state, which are owned, operated or managed by the applicant, any principals or any corporate entity related to the applicant (e.g. parent or subsidiary) which is similar or related to the service which is the subject of the application. If licensed out-of-state facilities are listed, submit track record reports for the preceding 12 months from the respective state agencies responsible for licensing those facilities. Attach additional sheets as necessary.

Name and Address of Facility	Medicare Provider Number

CERTIFICATION

I, _____ of full age, hereby certify that I'm employed with _____ in the capacity of _____ and am duty authorized to make the representations contained within this application for licensure on behalf of the applicant and to bind the applicant thereto; that the facility has been and will be operated in accordance with all applicable laws, rules and regulations, both state and federal; and that all information supplied in this application, including any and all attachments, are true, accurate and correct to the best of my knowledge. I am aware that if any of the information contained in this application, including any and all attachments, are willfully false or misleading, I and the applicant may be subject to civil and/or criminal penalties in accordance with applicable laws and/or other licensure enforcement activity, including, but not limited to facility loss of license in accordance with N.J.A.C. 10:161A and 10:161B.

Name of Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date

FOR TRANSFER OF OWNERSHIP

Name of Proposed Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date
Name of Current Operator or Authorized Representative ☐Mr. ☐Ms.	Title
Signature	Date

➔ ***IMPORTANT: Complete and forward one (1) original and one (1) copy to the above address. Please retain a copy for your records.*** ➔

DOH OFFICE OF LICENSING
REQUIRED APPLICATION DOCUMENTS

Upon receipt of all required documents, the DOH Office of Licensing will begin to process the application.
Submit one (1) original and (1) copy of a standard complete application packet containing the following:

☐ Application for Licensure form with all sections completed

☐ Licensing Application Fee: Check or money order payable to "Treasurer, State of New Jersey"

☐ Table of Organization, including titles, which shows reporting structure

☐ Copy of:
- Certificate of Incorporation and list of board of directors/trustees which includes names and current mailing addresses
  or
- Copy of Certificate of Partnership, including LLC, and list of partners/members with holding interest which includes names and current mailing addresses

☐ Copy of Federal/IRS and NJ Tax ID number certificates

☐ Synopsis of the applicant's service history or track record including services provided at any location within the United States for at least the last 12 months

☐ Provide one of the following:

- Where an agency is expanding a modality for which they are currently licensed, an attestation that the current policy and procedure manual, which has been approved by the OOL, will be used
  or
- Policies and Procedures as stipulated in the applicable regulations, including the following:

  ☐ Agency Brochures and Program Descriptions
  ☐ Client Rights and Grievance Procedure given to consumers/clients
  ☐ Confidentiality Policies and Notice of Privacy Practices
  ☐ Job Descriptions
  ☐ QA Plan or QA Policy and Procedure
  ☐ Infection Control Policy and Procedure

Mental Health Programs shall also submit:

☐ 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)

Substance Use Disorder Programs shall also submit:

☐ Staffing Qualification Form and copies of valid New Jersey professional licnses
☐ Schedules of counseling and didactic sessions
☐ Bed Bug Policy which includes prevention and treatment protocols version
☐ Emergency Disaster Plans

FACILITY: _____ SERVICES PROVIDED: _____ LICENSE NUMBER: _____
ADDRESS: _____ FED. TAX ID NO. _____ DATE: _____
EMAIL CONTACT PERSON COMPLETING THIS FORM: _____

Please only list the staff that work or are assigned to this licensed program. Copies of all professional licenses for those listed must be included. Please complete the shaded areas for staff with pending LCADC and/or CADC licenses. Use additional sheets, if needed, so that all ADMINISTRATIVE, MEDICAL, NURSING, & CLINICAL STAFF are included. This form must be used for your submission.

NAME OF EMPLOYEE	POSITION OR TITLE	FIELD OF DEGREE	ACTIVE CASE LOAD NUMBER *If a mixed caseload – designate how many cases and LOC	LCADC/CADC/CCS RN/APN/MD/DEA/CDS LIC EXP. DATE	IF NOT LCADC OR CADC CLASS HOURS TAKEN	IF NOT LCADC OR CADC EXPERIENCE HOURS	DATE WRITTEN TEST TAKEN	DATE ORAL TEST TAKEN	ANTICIPATED DATE OF COMPLETION
	CEO/President/Exec Dir								
	Administrator of Facility (see NJAC 10:161A/B 1.7)								
	Director of Sub. Abuse Counseling (see NJAC 10:161A/B 1.8)								
	Medical Director (if applicable) see NJAC 10:161A/B 1.4								
	Director of Nursing (if applicable) see NJAC 10:161A/B 1.5								
	Psychiatrist (if applicable)								
	Subs. Abuse Lic. Counselor OR Intern (see NJAC 10:161A/B 1.9)								
	Subs. Abuse Lic. Counselor OR Intern see NJAC 10:161A/B 1.9								
	Subs. Abuse Lic. Counselor OR Intern (NJAC 10:161A/B 1.9)								
	Subs. Abuse Lic. Counselor/Intern – (NJAC 10:161A/B 1.9)								
	Mental Health professional If approved for co-occurring (NJAC 10:161A/B 10.4)								

DOH OFFICE OF LICENSING
PHYSICAL PLANT REQUIRMENTS

Upon advisement of the Office of Licensing, please submit the following documents (as applicable) to initiate the physical plant inspection.

Physical Plant Documentation Checklist

All Applicants	OOL USE ONLY		
	YES	NO	N/A
Certificate of Occupancy (SUD Ambulatory Programs Use Group B, SUD Residential Programs Use Group I-1)			
Valid Certificate of Fire Inspection			
Sanitary Inspection Certificate (if food is prepared)			
Annual Elevator Inspection (if applicable)			

SUD Applicants Only	OOL USE ONLY		
	YES	NO	N/A
Copy of lease agreement or deed for the proposed location			
Inspection documentation from the vendor contractor for the Fire Alarm and Smoke Detection System			
Inspection documentation from the vendor contractor for the HVAC/Boiler and Hot Water heater			
Written approval from local authority or local official for water supply and sewage disposal system if not connected to a municipal system.			
Emergency Disaster Plans (if not already submitted with application)			
Sprinkler system inspection within the last 12 months (if applicable)			
Housekeeping contract and detailed chores schedule			
Pest Control contract denoting service schedule			

Physical Plant On-Site Inspection Requirements

The following shall be available at the time of the Office of Licensing's Physical Plant Evaluation:

- Postings in place as required (e.g., Grievance Procedure, Client Rights, emergency evacuation routes, emergency phone numbers, etc.)
- All exit signs and emergency lights shall be tested by applicant during the site visit
- Fire extinguishers as per regulation