



**Behavioral Health Licensing Unit**

Two Peachtree Street NW, Suite 23.277, Atlanta, GA 30303-3142 Telephone 404-657-1652 Fax 770-359-4655

**CRISIS STABILIZATION UNIT  
APPLICATION AND USER'S GUIDE FOR INITIAL OR NEW LICENSURE**

<input type="checkbox"/> <b>ADULT CSU</b>	<input type="checkbox"/> <b>CHILD/ADOLESCENT CSU</b>
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This is an application and User's Guide to apply for a **Crisis Stabilization Unit License**. Other requirements for licensure and informational materials are available on line at <http://dbhdd.org/bhlu>

A Crisis Stabilization Unit (CSU) is a medically monitored, short-term residential program licensed by the Department of Behavioral Health and Developmental Disabilities as an emergency receiving and evaluating facility to provide psychiatric stabilization and detoxification services twenty-four (24) hours a day, seven (7) days a week.

This application and User's Guide may be used to apply for:

- An **Initial License**
- A **New** license due to **Change of Ownership** of a currently licensed CSU.

The application, fees, and other documents must be submitted to the Department of Behavioral Health and Developmental Disabilities (DBHDD) **no later than ninety (90) calendar days prior** to the projected opening date of the CSU. No application will be acted upon until the Department determines that the application is complete with all required attachments and applicable fees submitted, as required by the Departmental Rules and Regs, Chapter 82-3-1-5.

**Note: A separate application and licensure request must be submitted for each CSU location.**

The Department shall conduct announced and unannounced on-site reviews and inspections of all facilities and services to determine compliance with Rules and Regulations for Crisis Stabilization services **prior to the issuance of a license or at any time while CSU services are operational.**

**Table of Contents:**

Requirements for Licensure.....Page 3

Additional Documentation Requirements.....Page 4

Submission Requirements..... Page 4

CSU Application Form.....Page 5

Attachment A: Ownership Addendum.....Page 11

Attachment B: Application Checklist.....Page 12

## **REQUIREMENTS FOR LICENSURE (GA. COMP. R. & REGS. 82-3-1-.04 TO -.05)**

All application materials must be submitted to the Department no later than ninety (90) calendar days prior to the projected opening date of the CSU and must include the following:

1. An accurate and complete application form (*see attached*);
2. A working budget showing projected revenue and expenses for the first year of operation, including revenue plan;
3. Documentation of working capital:
  - a. If the applicant is a sole proprietor, a corporation, a limited partnership, a limited liability company, or a hospital authority: Funds or a line of credit sufficient to cover at least 90 days of operating expenses must be documented;
  - b. If the applicant is a public entity: Appropriate revenue must be documented;
4. Documentation of authority to conduct business in the State of Georgia;
5. A twenty-four (24) hour staffing plan which includes all staff and other persons providing services to individuals at the CSU;
6. A certificate of occupancy and a campus map of the premises that describes the buildings, grounds, and the manner in which the various parts of the premises are intended to be used. Also include the names of the buildings, the licenses held by each building, the number of beds in each building, and a floor plan with dimensions and with space and room function designations for each building;
7. Photocopies of operating agreements with treatment facilities for psychiatric, addictive disease and physical health care needs that are beyond the scope of the CSU;
8. A program description signed by the Medical Director that includes, consistent with Departmental rules, admission and discharge criteria and procedures, including reasons for denial of admission, for both voluntary and involuntary individuals who do not meet CSU admission criteria;
9. Proposed daily schedule of treatment and education options throughout twelve (12) waking hours each day, including treatment and educational opportunities responsive to the mental health, physical health, and addictive disease issues represented by individuals in service;
10. A copy of a fire safety survey indicating approval by the local fire authority in whose jurisdiction the CSU is based that is dated no earlier than one year prior to the opening date. For new construction, additions, and renovation projects, written approval by the local building department must be included in addition to fire authority approval;
11. Documentation of accreditation as required by Departmental policy;
12. A license fee of \$200.00 per bed plus any other applicable fees submitted by check or money order; no cash payments are accepted by the Department. All fees are nonrefundable.<sup>1</sup>

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**Note:** The Department may revoke any license if the CSU has failed to pay the licensure activity fees within sixty (60) days of receipt of a written invoice from the Department. Fees collected by the Department are not refundable. Ga. Comp. R. & Regs. 82-3-1-.04(4-5).

## **ADDITIONAL DOCUMENTATION REQUIREMENTS**

1. Documentation of certification or compliance (if applicable) by Departmental policy;
2. Copy of Commercial General Liability or Comprehensive Liability Insurance Certificate;
3. Evidence of Delivery of Behavioral Health services for at least one year prior to submission of application;
4. Organizational Chart of the agency.

## **SUBMISSION REQUIREMENTS**

The completed DBHDD application, with all required documentation must be submitted simultaneously. **The Department will not accept incomplete application packets.**

Application and supporting documentation must include a single hard copy of all elements, submitted in a 3-ring binder and tabbed for easy review. **Documents must be submitted in the same order as listed on the checklist.**

Completed packets must be returned via U.S. Postal Service or other recognized mail carriers, such as UPS, Fed-Ex, DHL, etc.

Please mail completed application, supporting documentation and fees to:

**Department of Behavioral Health and Developmental Disabilities  
Behavioral Health Licensing Unit  
2 Peachtree Street  
Suite 23.277  
Atlanta, Georgia 30303-3142**

***HAND DELIVERIES WILL NOT BE ACCEPTED***

**A. Corporate Information:**

Legal Name: \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

FEI Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

**Owner** (if applicable): \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**CEO/Director:** \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**B. Georgia Headquarters (*Legal name and address registered with the GA Secretary of State*)**

Legal Name: \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

FEI Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

\_\_\_\_\_

**Georgia Director:** \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Contact Name** (Name of the person completing this application): \_\_\_\_\_

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Human Rights Contact Name:** \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**C. Proposed CSU Site**

Name of CSU: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

County in which CSU is located: \_\_\_\_\_

Clinical Contact Person: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Does this location have a Telecommunications Device for the Deaf (TDD)?

- Yes
- No



Provide the number of direct support staff working in this CSU\_\_\_\_\_. (Aides, paraprofessionals, technicians).

**MEDICAL DIRECTOR**

Please provide the name and address of the Medical Director in charge of the care and treatment of individuals receiving services in the CSU.

_____	_____
Name of the Medical Director ( <i>Please print</i> )	License Number/Expiration Date
Address: _____	
Street	
_____	
City/State/Zip	
_____	
Telephone Number	E-Mail

**NURSING ADMINISTRATOR**

Please provide the name and address of the Nursing Administrator in charge of the nursing staff in the CSU.

_____	_____
Name of the Nursing Administrator ( <i>Please print</i> )	License Number/Expiration Date
Address: _____	
Street	
_____	
City/State/Zip	
_____	
Telephone Number	E-Mail

**E. Bed Information**

Number of Crisis Beds: \_\_\_\_\_

Number of Transitional Beds: \_\_\_\_\_

Total Number of Beds: \_\_\_\_\_

*NOTE: Transitional bed designation in a CSU shall be made on the following basis:  
1-16 total beds shall designate at least one of those beds as a transitional bed.  
17-29 total beds shall designate at least one but up to two of those beds as transitional beds.  
30-39 total beds shall designate at least one but up to three of those beds as transitional beds.  
40+ total beds shall designate at least two but up to four of those beds as transitional beds.*

**F. Fees**

A fee of \$200.00 per bed shall be paid to the Department by check or money order. No cash payments are accepted by the Department. **Fees are non-refundable.**

*All licenses issued by the Department require payment of ongoing licensure activity fees as determined by the Department each state fiscal year, including the state fiscal year that these rules take effect. For continuing licenses, such ongoing licensing activity fees will be due on the renewal date. The fees shall include the base licensure activity fee and any additional fees incurred during the previous year. Such fees are due and payable to the Department within thirty (30) days of receipt of the licensure activity fee invoice. Fees will be determined by the Department in a manner to help defray the direct and indirect costs incurred by the Department in providing such licensure activities for this program, but in no event shall exceed such costs.*

*The Department may revoke any license if the CSU has failed to pay the licensure activity fees within sixty (60) days of receipt of a written invoice from the Department. The revocation action is subject to written notice of the proposed revocation and a right to receive an administrative hearing on the amount past due and owing prior to the revocation action becoming final.*

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<b><u>FEE CALCULATION</u></b>		
_____	x \$200	= _____
<i>Total Number of Beds at this Facility Location (Crisis Beds + Transitional Beds)</i>	<i>Fee Per Bed</i>	<b>TOTAL FEE OWED</b>

**SIGNATURE AND CERTIFICATION**

I certify that all information in this application is correct and that all copies submitted with the application are original copies or copies of the original documents. I understand that intentionally providing false information on this form or attachments is a violation of state law. I also understand that applications submitted electronically, via e-mail or similar media, are not valid unless I enter my name in the signature field below and such action shall constitute an electronic signature.

\_\_\_\_\_  
Chief Executive Officer or Administrator's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of CEO or Administrator

\_\_\_\_\_  
Title

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number (include Area Code)

\_\_\_\_\_  
E-mail

**ATTACHMENT A: OWNERSHIP ADDENDUM**

Please complete this form **if** the owner is a partnership with persons as partners, or a corporation in which a person has an ownership interest of at least 25% of the business entity. Attach additional pages if necessary.

**The owner is a [select one]:**

**Limited Partnership – List each person who is a general partner.**

*(Attach additional pages if necessary.)*

- Profit
- Non-Profit

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Corporation or Limited Liability Company – List any person who has an ownership interest of 25% or more in the corporation or LLC.**

*(Attach additional pages if necessary)*

- Profit
- Non-Profit

Print Name: \_\_\_\_\_ Percent Ownership: \_\_\_\_\_%

Print Name: \_\_\_\_\_ Percent Ownership: \_\_\_\_\_%

Print Name: \_\_\_\_\_ Percent Ownership: \_\_\_\_\_%

Print Name: \_\_\_\_\_ Percent Ownership: \_\_\_\_\_%

## ATTACHMENT B: APPLICATION CHECKLIST

**REMEMBER: All application materials must be submitted to the Department no later than ninety (90) calendar days prior to the projected opening date of the CSU.**

**Have you completed and included the following?**

- An accurate and complete application form;
- A working budget showing projected revenue and expenses for the first year of operation, including revenue plan;
- Documentation of working capital:
  - a. If the applicant is a sole proprietor, a corporation, a limited partnership, a limited liability company, or a hospital authority: Funds or a line of credit sufficient to cover at least 90 days of operating expenses must be documented
  - b. If the applicant is a public entity: Appropriate revenue must be documented;
- Documentation of authority to conduct business in the State of Georgia;
- A twenty-four (24) hour staffing plan which includes all staff and other persons providing services to individuals at the CSU;
- A certificate of occupancy and a campus map of the premises that describes the buildings, grounds, and the manner in which the various parts of the premises are intended to be used. Also include the names of the buildings, the licenses held by each building, the number of beds in each building, and a floor plan with dimensions and with space and room function designations for each building;
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- A program description signed by the Medical Director that includes, consistent with Departmental rules, admission and discharge criteria and procedures, including reasons for denial of admission, for both voluntary and involuntary individuals who do not meet CSU admission criteria;
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- A copy of a fire safety survey indicating approval by the local fire authority in whose jurisdiction the CSU is based that is dated no earlier than one year prior to the opening date. **\*For new construction, additions, and renovation projects, written approval by the local building department must be included in addition to fire authority approval;**
- Documentation of accreditation as required by Departmental policy;

- Documentation of Certification (if applicable);
- Copy of General Liability or Comprehensive Liability Insurance;
- If required, Evidence of Delivery of Behavioral Health services for at least one year prior to submission of application;
- Organizational chart of the agency, including names and titles of all employees.