Georgia Department of Behavioral Health & Developmental Disabilities
Frank E. Shelp, M.D., M.P.H., Commissioner

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 RENEWAL LICENSURE

☐ ADULT CSU	☐ CHILD/ADOLESCENT CSU

This is an application and User's Guide to apply for a **renewal of a Crisis Stabilization Unit License**. 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:

- **Renewal** of a currently held license

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 expiration date of the current license. 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.**

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REQUIREMENTS FOR RENEWAL 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 expiration date of the current license and must include the following:

1. An accurate and complete application form (*see attached*);

2. A twenty-four (24) hour staffing plan which includes all staff and other persons providing services to individuals at the CSU;

3. Photocopies of operating agreements with treatment facilities for psychiatric, addictive disease and physical health care needs that are beyond the scope of the CSU;

4. 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;

5. 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;

6. A copy of the most current 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;

7. Documentation of accreditation as required by Departmental policy.

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;

5. Documentation of accreditation by Departmental policy.

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

CSU APPLICATION FOR RENEWAL PROVIDER

Current License #: _____

Expiration Date of Current License: _____

** ***Please Note****: It is the responsibility of the CSU to complete and submit a renewal application postmarked at least 90 calendar days prior to the expiration date of the current license. If the CSU fails to submit the completed renewal application and fee(s), the Department shall provide notice by certified mail advising that unless the renewal application and licensure review is satisfactorily completed, the CSU is operating without a valid license and is subject to sanctions.*

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

D. Bed Information

Number of Crisis Beds: _____

Number of Transitional Beds: _____

Total Number of Beds: _____

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.

E. Staffing

Professional Personnel			
Name	**Credentials**	**License #**	**FTE**

Professional Personnel Contractors		
Agency	**Address**	**Phone #**

☐ If more space is necessary to respond to this section, a copy of this page may be attached as an additional appendix to this application and should be noted by the checking of this box.

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 (*Please print*) 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 (*Please print*) License Number/Expiration Date

Address: _____

Street

_____

City/State/Zip

_____

Telephone Number E-Mail

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.

FEE CALCULATION

_____	x	$200	=	_____
Total Number of Beds at this Facility Location (Crisis Beds + Transitional Beds)		*Fee Per Bed*		**TOTAL FEE OWED**

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 expiration date of the current license.

Have you completed and included the following?

☐ An accurate and complete application form;

☐ A twenty-four (24) hour staffing plan which includes all staff and other persons providing services to individuals at the CSU;

☐ Photocopies of operating agreements with treatment facilities for psychiatric, addictive disease and physical health care needs that are beyond the scope of the CSU;

☐ 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;

☐ 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;

☐ A copy of the most current fire safety survey indicating approval by the local fire authority in whose jurisdiction the CSU is based. ***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;

☐ 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.