North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure & Certification Section

Change
Licensure Application Packet

Form# DHHS/DHSR/MHL5002
Revised 11/08/2024

Mental Health Licensure and Certification Section
Tel 919-855-3795 • Fax 919-715-8078
Location: Williams Building • 1800 Umstead Drive • Raleigh, NC 27603
Mailing Address: 1800 Umstead Drive • 2718 Mail Service Center • Raleigh, NC 27699-2718

N.C. Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
1800 Umstead Drive ■ 2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change application.
2. Failure to provide all requested information will delay the application's processing if the information does not pertain to your facility mark N/A in the area.
3. Change requests must be **submitted at least 30 days prior to the anticipated change**.
4. A change in the ownership of a license has an associated fee that must be submitted with the application. The Change of Ownership fee is shown on the chart at the end of the instructions. In addition, construction-related fees will be invoiced to you at a later date (change of capacity, change of location).
5. Ensure all required information is submitted and the application is with correct information.

Submitting a Change application does not guarantee that the change is granted. The applicant will still need to complete the application process successfully with the Licensure & Training Team*

Type of Licensure Change Application

1. Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other." You can check multiple boxes if requesting multiple changes.
   - ***Change of Location***: Moving a facility. See Change of Location Checklists (pages 3 &4).
   - ***Change of Capacity***: If capacity increases, you must submit photos & a floor plan with documented dimensions of the bedrooms. Capacity increases over 6 per bed require a per-bed fee of $19.00 for beds over 6.
   - ***Change of Service Category***: New letter of support (LOS) is needed from the LME/MCO. LOS must be current (year or less).
   - ***Change of Facility Name***: Changing a facility name.
   - ***Change of Licensee/Ownership (CHOW)***: Complete this application. Signatures are ***required*** for the current licensee/owner and the prospective new licensee/owner (or designees) on page 1 of the change application. A fee is assessed for a change of ownership which must accompany the application. ***The Change of ownership of the license is entirely separate from any business transaction between providers. Until the license has officially been granted a transfer by the Licensure & Training Team to the new prospective provider, the original owner/licensee is responsible for their facility and the people served.***
2. **Facility MHL#:** May change with the type of change. Enter the Facility's current Mental Health License number.

Current Information

1. Current Facility Name: Enter the name printed on your most current license.
2. Current Facility Site Address: This address is the physical site location printed on the most current license.
3. Current Legal Identity of Ownership/Licensee: This is the name printed on your license as the licensee/owner. Please complete the address, phone and email information.
4. Signature of Current Licensee: Current licensee or designated authority for the licensee must sign and date here. For a change in ownership request, see the above-italicized directions for Change of Licensee/Ownership.
5. Signature of Requested New Licensee: If a change of ownership is requested, the new licensee must sign here.

There is a change of ownership fee (see "change of ownership fee).

Requested Changes

On the Requested Changes page, please complete ***only*** those changes you are requesting.

1. Facility Name: Enter the requested facility's name that will be printed on your license.
2. Facility Site Address: Enter the new physical location of your facility.
   NOTE: If you are changing locations, please make sure the building code classification for the new address is in compliance with the program(s) to be licensed.

3. Facility Correspondence Mailing Address: This address will be where you will receive all mail for the facility. Indicate the name to address correspondence.
4. Name of Contact Person: This could be you or the person responsible for managing the facility. This person can answer daily process and licensure questions about the facility.
5. Name and Signature of Licensee or Person with Signatory Authority
6. Management Company: Enter this information ***if the facility will be managed by a company other than the licensee.***
7. Local Management Entity/Manage Care Organization (LME/MCO): Enter the names of LME/MCOs with which the facility has a contract.
8. Legal Identity of Ownership/Licensee: This is the name that will be printed on the license as licensee/owner.
   (a) Enter the name and contact information of the new owner.
   (b) Federal Tax ID# - if applicable.
   (c) National Provider Identifier (NPI).
   (d) Check if you are registered with the state as a profit or non-profit.
   (e) Type of entity under which the business is operated. All entities should be registered with the state except proprietorships and private partnerships.
   (f) Supply information for CEO or President. And If you lease the building, complete the data on the person from whom you lease/rent.
9. Owners, Partners, Affiliates, Shareholders (Confidential Information for Official Use Only):
   - If the ownership has investors or shareholders in the business, fill in the information requested. If ownership is a corporation/company having only 1 person who is the sole owner, please fill in as percentage interest is 100%.
   - If this is a non-profit entity, the signature and title and date are needed in the provided box.
   - If proprietary ownership, complete the box as if a shareholder.
10. Extensions in Ownership: Enter information about Affiliates who directly or indirectly control the owner of this facility.
11. Service Categories: Note the changes or additions to the service category. If a change in the service category, complete the "from" and "to" entries. Check the category that describes the service/s your facility will provide. For example, enter the number of beds for residential facilities under either the Children category or the Adult category. An increase of beds above 6 may require invoicing by DHSR for an additional fee.
12. Certificate of Need: Note if you have a certificate of need for a required service category and the CON # and date.
13. Ambulatory/ Non-Ambulatory Beds: Complete only if you are requesting a change of Ambulatory Beds to Non-Ambulatory Beds.
14. Number of Others Living in the Facility: Complete only if requesting service category *.5600F or.5100-Private Home Respite*. Include the number and age of anyone that lives in the facility that is not a client.

Construction Fees

The DHSR Construction Section has a per-project fee to review the physical plant requirements for ***24-hour residential facilities only*****.** You will receive an invoice from the Construction Section for the appropriate fee. Following is a list of fees:

Type of Facility	**Number of Beds**	**Project Fee**
Non-ICF/IID Facilities	1-3	$125.00
Non-ICF/IID Facilities	4-6	$225.00
Non-ICF/IID Facilities	7-9	$275.00
ICF/IID Facilities	1-6	$350.00
Other Residential	10 or more	$275.00 + $.15/sq. ft. project space

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Change of Ownership Fees

The Operations and Capital Improvements Appropriations Act of 2006 instituted a fee for all residential and non-residential facilities.

Following is a list of types of facilities that require a change of ownership fee, including the base fee and the per bed fee.

Type of Facility	Number of Beds	Base Fee	Per Bed Fee
Non-residential Facilities	0	$215.00	N/A
Residential Facilities (Non-ICF/IID)	6 beds or less	$305.00	$0
Residential Facilities (Non-ICF/IID)	7 beds or more	$475.00	$17.50
ICF/IID Facilities	6 beds or less	$845.00	$0
ICF/IID Facilities	7 beds or more	$800.00	$17.50

Make check payable to
N.C. Division of Health Service Regulation

Send application with the required information to:
Division of Health Service Regulation
MH Licensure & Certification Section
1800 Umstead Drive
2718 Mail Service Center
Raleigh, NC 27699-2718

Change Application Checklist

Incomplete applications will be returned to the sender without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the correct checklist below if you are requesting a change of location before submitting your license application.

Requirements for 24-hour Residential Programs

Requirements for 24-hour Residential Programs—Existing Structures

Note: Before the construction of a ***new 24-hour residential*** facility, you must submit blueprints and receive approval from the DHSR Construction Section. For additional information, contact DHSR Construction at 919-855-3893.
Please submit the following below:

1. A floor plan that specifies the following:
   a. All levels, including basements and upstairs.
   b. Identification of the use of all rooms/spaces.
   c. Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
   d. Location of all doors and the dimensions of all exterior doors.
   e. Location of all windows, including the dimensions of bedroom windows and sill height of bedroom windows above the finished floor.
   f. The location of all smoke detectors noting whether they are battery-operated wired into the house current with battery backup, and interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Provide current *Secretary of State Report* (https://www.sosnc.gov/corporations) documenting Active Status.
5. **Local Zoning Department approval** for the proposed use**.**
   The zoning compliance letter from your local zoning department must clearly identify:
   - ***Facility address***
   - ***Zoning code (must be correct zoning code; see below chart)***
   - ***Intended usage.***

Your application will not be processed if your zoning compliance information does not contain and verify the correct zoning.

6. Current (within a year) Letter of support from LME/MCO (Only required when changing Counties)
7. Appointments for Fire & Sanitation Inspections.

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Change of Location Checklist: Residential

	Item	Completed
1	Completed Change Licensure Application (form DHSR 5002)	
2	Floor Plan with the dimensions of bedrooms, Identifying all spaces in the facility. (All levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
3	Pictures (Interior & Exterior)	
4	Directions to Facility	
5	Zoning Approval (original – within 1 year of application date) *Required for application to move forward*	
6	LME-MCO Support Letter *Only needed if a location change is in a different county than the facility is currently located.	
7	Appointments for Fire & Sanitation Inspections. Actual inspections are not needed when submitting the application but will be needed prior to DHSR Construction section approval.	

Requirements for Day Programs

Requirements for Day Programs

Note: Day Programs for children and adolescents ***cannot*** be located in a building classified as a Business Occupancy. These programs are required to meet either Group E-Educational Occupancy or Group I-4 - Child Daycare Occupancy under the NCSBC.

Please submit the following:

1. A floor plan of the entire building or floor within the building of the space to be licensed that specifies the following:
   a. Identification and dimensions of rooms to be licensed.
   b. Exits from the licensed space and building.
   c. Toilet areas and other required support spaces.
2. Exterior photos of each side of the building. Interior photos of the proposed licensed space.
3. Provide current *Secretary of State Report* (https://www.sosnc.gov/corporations) documenting Active Status.
4. Local Zoning Department approval or verification that the facility is classified under building/planning for the intended use.
5. Current local Fire Marshal's Inspection Report for the building.
6. Current local Sanitation Inspection report if serving any food.
7. A preliminary program approval letter is required from the State Opioid Treatment Authority (SOTA) for all Service Category 3600 facilities.
8. New Construction/Renovation: the local Building Official's approval.
9. Existing Structure: If this is an existing Business Occupancy building (as classified under the North Carolina State building code) and it is only a change of tenant use (for a program that is classified as a 'Business Occupancy use') approval from the local Building Official may not be required. Contact your local Building Official and provide them with a copy of your application to verify if your program is classified as a Business Occupancy and if they need to provide any type of documentation.

Change of Location Checklist: Day Program

	Item	Completed
1	Completed Change Licensure Application (form DHSR 5002)	
2	Floor Plan Identifying all spaces in the facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
3	Pictures (Interior & Exterior)	
4	Provide current Secretary of State Report (https://www.sosnc.gov/corporations) documenting Active Status.	
5	Zoning Approval (original – within 1 year of application date) *Required for application to move forward*	
6	Fire & Sanitation Inspections. (Sanitation inspection only needed if the facility will be serving food)	

***Note:** If you are changing locations, please make sure the building code classification for the new address is in compliance with the programs being licensed (see Building Code Classifications page below).*

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CHANGE LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF CHANGE:

FACILITY MHL#:_____

MHH#: _____

- ☐ Facility Name
- ☐ Change in Capacity*
- ☐ Licensee/ Ownership**
- ☐ Service Category and Code
- ☐ Ambulatory Bed(s) to Non-Ambulatory Bed(s)
- ☐ Change of Location* ☐ Within the Same County ☐ Into a Different County
- ☐ Change of Shareholders:
- ☐ Adding a Mental Health Service to a Mental Health Hospital
- ☐ Other; Please Specify: _____

**Change of Location & Change of Capacity requires a Construction Fee. You will be invoiced for these fees. Do not send money for Construction Section when submitting this application. An increase in capacity over 6 beds requires a licensure fee. Change in Ownership requires a license fee to accompany this application. **

CURRENT LICENSE INFORMATION (complete requested changes on following pages)

1. CURRENT FACILITY NAME: _____

2. CURRENT FACILITY SITE ADDRESS: (NO P.O. BOXES)

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: _____Email: _____

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____ Email: _____

4. SIGNATURE OF CURRENT LICENSEE: The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____Title: _____

Signature: _____Date: _____

5. SIGNATURE OF NEW LICENSEE (if applicable): The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____Title: _____

Signature: _____Date: _____

EMAIL: _____Phone #: _____

ALL APPLICATIONS MUST BE MAILED TO THE ABOVE ADDRESS AND MUST HAVE AN ORIGINAL SIGNATURE

Below Box is Office for Use ONLY

Licensure Categories: _____ *Check #* _____ *Check Amount:* _____ *SOS:* _____ *PPT:* _____

MFF: _____ *ACCESS:* _____ *ACO:* _____ *PR:* _____ *Staff Initials:* _____

Remarks: _____

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REQUESTED CHANGES

In application pages 2-6, please complete *ONLY* those changes being requested.

1. **REQUESTED FACILITY NAME:** _____
   *Name which facility is advertised or presented to the public. This is the name that will be printed on your license. Refer to this facility name in **all** inquiries.

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2. **REQUESTED FACILITY SITE ADDRESS:** (NO P.O. BOXES) **(Please note you cannot move to the new location until you have received your new license for this location.)**

   Street Address: _____

   City: _____ State: _____ Zip Code: _____ County: _____

   Phone: _____Email: _____

   Must be a designated permanent operable phone prior to licensing.

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3. **REQUESTED FACILITY CORRESPONDENCE MAILING ADDRESS:**

   Street Address: _____

   City: _____ State: _____ Zip Code: _____ County: _____

   Phone: _____Email: _____

   Email Address (to which all correspondence will be sent)

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4. **NAME OF CONTACT PERSON for Application Process:**

   Name: _____Title: _____

   EMAIL: _____Phone #: _____

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5. **SIGNATURE OF LICENSEE OR PERSON WITH SIGNATORY AUTHORITY:** The undersigned, representing the governing authority, submits information for the above-named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

   Name: _____Title: _____

   Signature: _____Date: _____

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6. **REQUESTED MANAGEMENT COMPANY:** If a facility is managed by a company ***other than the licensee***, provide the following information about the Management Company:

   Name of Company/Contact Person: _____

   Street Address: _____

   City: _____ State: _____Zip Code: _____

   Phone: _____Email: _____

7. **LOCAL MANAGEMENT ENTITY/ MANAGED CARE ORGANIZATION (LME/MCO)** (List name(s) of LME/MCOs with which the facility has a contract):

   _____

8. **LEGAL IDENTITY OF OWNERSHIP/LICENSEE:**

The full legal name of an individual, partnership, corporation or other legal entity that owns the mental health facility business is required. Owner/Licensee means any person/business entity (Corp., LLC, etc.) that has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for the financial and contractual obligations of the business and will be **recorded as the licensee on the license**.

(a) Name of Owner/Corporation: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email: _____

(b) Federal Tax ID number of Owner/Licensee: _____

(c) NATIONAL PROVIDER IDENTIFIER (NPI): _____

For Health Care Providers

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of a standard unique identifier for healthcare providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique **National Provider Identifier (NPI)**. If you have questions or need additional information regarding the NPI number, call the toll-free number 1-800-4653203 or visit the website: http://www.ncdhhs.gov/dma/NPI/index.htm

(d) Legal entity is: ☐ For Profit ☐ Not for Profit

(e) Legal entity is: ☐ Proprietorship ☐ Limited Liability Company
☐ Corporation
☐ Partnership ☐ Limited Liability Partnership
■ Government Unit

(f) Name of CEO/President: (First, MI, Last) _____

Title: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email: _____

Building Owner: If the above entity (partnership, corporation, etc.) ***does not*** own the building from which services are offered, please provide the following information: **Name of Building Owner:**

_____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Lease expires: _____

9. **OWNERS, PARTNERS, AFFILIATES, SHAREHOLDERS** (Confidential Information for Official Use Only)**:**

Complete the information below on **all** individuals, proprietorship or entities who are owners, partners, affiliates or shareholders holding an interest of 5% or more of the applicant entity. Attach additional pages if necessary. *We ask that you voluntarily provide your social security number with the understanding that it will be used only as an identification number for internal record keeping and data processing.* If you are the only owner, complete the information below, listing the percentage interest as 100%. ***Documentation verifying that all parties agree to change should be submitted in the application. Please add additional sheet document current and change if needed.***

CURRENT SHAREHOLDERS

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

REQUESTED CHANGE

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

Shareholder Name: (First, MI, Last) _____Title: _____

Street Address: _____City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____ Percentage%: _____

10. **Non-Profit Companies and For-Profit Companies** (If no individual holds an interest of 5% or more, please sign the statement below.)

There are **no owners, principles, affiliates or shareholders who hold an interest of 5% or more** of the licensee applying for or renewing a license:

_____ _____ _____

Signature Title Date

11. **SERVICE CATEGORIES:**

Services subject to licensure under G.S. 122C are shown in the table below and are **found in the Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services**. All applicants (initial and renewal) must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank.

Changing from _____ to _____ **Adding _____** **Deleting _____**

10A NCAC 27G:	Description of Service Category	Check Service of License	Minor: 0-17	Adult: 18+	Total Beds
.1100	Partial Hospitalization for Individuals who are acutely Mentally Ill. Does not encompass SUD as a primary D/O				
.1200	Psychosocial Rehabilitation facilities for individuals with severe and persistent mental illness				
.1300	Residential Treatment Facilities For Children & Adolescents				
.1400	Day Treatment for children and adolescents with emotional or behavioral disturbances				
.1700	Residential Treatment Staff Secure for Children or Adolescents				
.1800	Intensive Residential Treatment for Children or Adolescents				
.1900	PRTF-Psychiatric Residential Treatment Facility for children and adolescents ***(allow service up to age 21)***				
.2100	Specialized Community Residential Centers for Individuals with Developmental Disabilities				
.2200	School Year, Before/After School and Summer Developmental Day Services for Children				
.2300	Adult Developmental Vocational Programs for Individuals with Developmental Disabilities				
.3100	Non-hospital Medical Detoxification-Individuals who are Substance Abusers				
.3200	Social Setting Detoxification for Substance Abuse				
.3300	Outpatient Detoxification for Substance Abuse				
.3400	Residential Treatment-Individuals with Substance Abuse Disorders				
.3600	Outpatient Opioid Treatment				
.3700	Day Treatment Facilities for Individuals with Substance Abuse Disorders				
.4100	Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children				
.4300	A supervised therapeutic community for individuals with substance abuse disorder				
.4400	Substance Abuse Intensive Outpatient Program (SAIOP)				
.4500	Substance Abuse Comprehensive Outpatient Treatment (SACOT)				
.5000	Facility Based Crisis Service for Individuals of all Disability Groups				
.5100	Community Respite Services for Individuals of all Disability Groups				
.5200	Residential Therapeutic Camps-Children & Adolescents-all Disability Groups				
.5400	Day Activity for Individuals of all Disability Groups				
.5500	Sheltered Workshops for Individuals of All Disability Groups				

	.5600 supervised living for individuals of all disability groups (CON required for ICF/IID facility). Only One from the ".5600" categories can be chosen.	Check Service of License	Minor: 0-17	Adult: 18+	Total Beds
.5600A	Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients)				
.5600B	Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600C	Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600D	Group homes for minors with substance abuse problems				
.5600E	Supervised Living for Adults with Substance Abuse Dependency				
.5600F	Supervised Living: Alternative Family Living in a Private Residence (max 3 clients)				

12. **DO YOU HAVE A CERTIFICATE OF NEED?**

Required for the following service categories: .2100, & .5600 (only when ICF/IID facility)

☐ No

☐ Yes If yes, CON Number: _____ Date CON Received: _____

- **Do you plan on serving clients requiring blood sugar checks?** Yes ☐ No ☐

*If yes **and** your staff will be conducting blood sugar checks, you must apply for a CLIA waiver before conducting blood sugar checks. Please contact DHSR's Acute & Home Care section's CLIA branch for information on obtaining CLIA waiver: https://info.ncdhhs.gov/dhsr/ahc/clia/index.html

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13. AMBULATORY/NON/AMBULATORY BEDS

Type	Current License	Requested Change
Ambulatory*		
Non-Ambulatory, 1-3		
Non-Ambulatory, 4 or more		
Total number of clients serving		

Ambulatory: a person who can evacuate a building without physical or verbal assistance during a fire or other emergency.

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14. **NUMBER AND AGE(S) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:**

(Applicable only in categories where the private residence is allowable: .5600 F & .5100 Private Home Respite)

_____

Are any of the above people non-ambulatory? Yes ☐ No ☐

An interpretation the NC Department of Insurance determined in June of 1998. that any child under the age of six residing in a licensed Home (MHL, FCH or Child Care etc.) is considered non-ambulatory and, as such, must be considered as part of the home's licensed census, as the child will require attention in addition, to the care the licensed clients of the home will also require, this would also apply for an aged or disabled family member that needs assistance residing the home.

CONSTRUCTION: PHYSICAL PLANT

Please fill in EACH inspection Department information if a change of location:

Zoning Department Official

Department Name: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Building Official

Department Name: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Fire Marshall

Department Name: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Local Sanitation

Department Name: _____

Street Address: _____

City: _____State: _____ Zip Code: _____

Phone: _____ Email: _____

Building Information: Complete for 24-hour residential facilities only: Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility: _____

Previous License #: _____ Dates of Licensure: From: _____ To: _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If yes, please clarify the type of license _____

Is the building a site-constructed home or a manufactured/mobile home? _____

NOTE: If it is a manufactured/mobile home, contact the DHSR Construction Section for licensure limitations on this type of structure)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐

Building Code Zoning Classifications - Requirements for Licensure Categories (revised 7/7/2015)

Program Code 10 NCAC 27G	Facility Type	24-hour programs	Building Classification	Code
.1100	Partial Hospitalization for individuals who are acutely mentally ill	No	Group B – Business Occupancy (Adults) Group E – Educational or I-4 (Minors)	a
.1200	Psychosocial Rehab for individuals with Severe and Persistent Mental Illness	No	Group B – Business Occupancy	a
.1300	Residential Treatment for Children or Adolescents	Yes	Residential – Classification dependent on number & ambulation status	b
.1400	Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances	No	Group E – Educational Occupancy or I-4	a
.1700	Residential Treatment Staff Secure for Children or Adolescents	Yes	Residential – Classification dependent on number & ambulation status	d
.1800	Intensive Residential Treatment for Children or Adolescents	Yes	Institutional Occupancy	e
.1900	Psychiatric Residential Treatment for Children and Adolescents	Yes	Institutional Occupancy	f
.2100	Specialized Community Residential Centers for Individuals with Developmental Disabilities	Yes	Residential or Institutional Occupancy	g
.2200	Before/After School and Summer Developmental Day Services for Children with or at Risk for Developmental Delays, Developmental Disabilities, or Atypical Development	No	Group E- Educational or I-4	a
.2300	Adult Developmental and Vocational Program for Individuals with Developmental Disabilities	No	Group B- Business Occupancy	a
.3100	Nonhospital Medical Detoxification for Individuals who are Substance Abusers	Yes	Institutional Occupancy	h
.3200	Social Setting Detoxification for Substance Abusers	Yes	Residential or Institutional Occupancy	m
.3300	Outpatient Detoxification for Substance Abuse	No	Group B – Business Occupancy	a
.3400	Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders	Yes	Residential or Institutional Occupancy	i
.3600	Outpatient Opioid Treatment	No	Group B- Business Occupancy	a
.3700	Day Treatment Facilities for Individuals with Substance Abuse Disorders	No	Group B- Business Occupancy Group E – Educational or I-4 (Minors)	a
.4100	Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children	Yes	Typically Group R – Residential	j
.4300	Therapeutic Community	Yes	Typically Group R – Residential	k

.4400	Substance Abuse Intensive Outpatient Program (SAIOP)	No	Group B – Business Occupancy (Adults) Group E – Educational or I4 (minors)	a
.4500	Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	No	Group B- Business Occupancy	a
.5000	Facility-Based Crisis Services for Individuals of All Disability Groups	Yes	Institutional Occupancy	l
.5100	Community Respite Services for Individuals of All Disability Groups	Yes	Typically, Residential depending on the number of residents	m
.5200	Residential Therapeutic (Habilitative) Camps for Children and Adolescents of All Disability Groups	Yes	Wilderness Camp Settings	p
.5400	Day Activity for Individuals of All Disability Groups	No	Group B- Business Occupancy Group E – Educational or I4 (Minors)	a
.5500	Sheltered Workshops for Individuals of All Disability Groups	No	Group B- Business Occupancy	a
.5600	Supervised Living for Individuals of All Disability Groups	Yes	Residential	o
.6000	Inpatient Hospital Treatment for Individuals who have Mental Illness or Substance Abuse Disorders	Yes	Institutional Occupancy	l

Code	Program Type / Description
a	Day Program
b	Level II Clients
c	This program has been deleted
d	Level II clients (previously part of the .1300 program)
e	Level IV clients. Required to be a secured facility and Institutional – Unrestrained Occupancy (previously part of the .1500 program)
f	PRTF clients. May be staff secured or locked; still Institutional – Unrestrained Occupancy (previously part of the .1500 program)
g	Usually, these are ICF/IID facilities and required to have a Certificate of Need (CON)
h	Institutional occupancy since providing medical treatment
i	Typically, not in a six-bed facility since it requires CON
j	The program is for women and their children. Usually in apartment/motel situation but if less than six could be a home
k	Program is for adults and is usually in apartment/ motel situation, but if less than six could be in a home
l	Requires Institutional Occupancy since requiring treatment
m	Typically, it is with another residential program. However, it could be part of a larger facility that is not residential.
n	Support Services, not residential
o	Has six different programs. .5600A; .5600B; .5600C are limited to maximum of 6 clients. .5600F is limited to maximum of 3 clients in private residence.
p	Residential Camp
q	Any program not listed is not a licensed program by Mental Health

Programs typically licensed in Single-Family Dwellings and falling under G.S. 168 are: .1300, .1700, .2100, .5100 & .5600.

Additional Information

An applicant is allowed six months from the date contact is made with the applicant and a Licensure & Training team member to complete the program review of the application process.

- A person from the L&T team will contact you to begin the program review. Your 6 months' time frame begins from the initial contact with the L&T team member.
- Please note that if you are a residential service, the application must be processed with DHSR construction. DHSR construction time is separate from the MHLC timeframe.
- The amount of time it takes to complete an application process is driven by the readiness of the applicant • The L&T Team has a goal to get you licensed a lot sooner than 6 months, but you must be ready for the Licensure & Team Program Review to do this.

A full list of the required materials that will be reviewed can be found on the DHSR website under the forms and applications section. In addition, the policies and procedures worksheet that must accompany your policies and procedures can be found under the forms and applications section.