**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 8/1/2019

Mental Health Licensure and Certification Section
www.ncdhhs.gov/dhsr
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 result in delaying the processing of the application. If the information does not pertain to your facility mark N/A in the area.
3. Change requests must be **submitted at least 60 days prior to the anticipated change**.
4. A change in the ownership of a license has an associated fee which must be submitted with the application. The Change of Ownership fee is shown on chart at end of instructions. Construction related fees will be invoiced to you at a later date (change of capacity, change of location).

## Type of Licensure Application

1. **Facility MHL#:** Enter Facility Mental Health License number.
2. Check the appropriate box/boxes for the action you are requesting. If the action is not listed, fill in the blank beside "Other".
   - Change of Location: See Change of Location Checklists (pages 4 & 5).
   - Change of Capacity: If increase in capacity you must submit photos & floor plan. Capacity increases over 6 beds require a per bed fee of $19.00 for beds over 6.
   - Change of Service Category: New letter of support needed from the LME
   - Change of Facility Name: Complete this application.
   - Change of Licensee/Ownership: Complete this application. Signatures are ***required*** for the current licensee/owner and the prospective new licensee/owner (or designees) in #4 and #5 in the change application. A fee is assessed for a change of ownership which must accompany application.
   - Requested Effective Date of Change: Enter date when you are requesting that the change be effective. This may be related to other changes that are occurring with your business.

## Current Information

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

## Requested Changes

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

1. Facility Name: Enter the name of the facility 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 Facility Director: This will be the person who is responsible for managing the facility.
5. Name of Contact Person: This may be you or the person responsible for managing the facility. This person can answer daily process and licensure questions about the facility.
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 name and contact information of new owner.
   (b) Federal Tax ID# - if applicable.

(c) Check if you are registered with the state as profit or non-profit.
(d) Type of entity under which the business is operated. All entities should be registered with the state except proprietorship and private partnership.
(e) Supply information for CEO or President.
(f) 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 sole owner, please fill in as percentage interest is 100%.
   * If this is a non- profit entity, Signature and title and date needed in box.
   * If proprietary ownership, complete the box as if shareholder
10. Extensions in Ownership: Enter information about Affiliates who directly or indirectly control the owner of this facility.
11. Service Categories: Note the change or additions to service category. If change in service category complete "from" and "to" entries. Check the category that describes the service/s your facility will provide. For residential facilities, enter the number of beds under either the Children category or Adult category. Increase of beds above 6 may require invoicing by DHSR for 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. Number of Clients: Note the number of clients you will serve and the disability category or categories that you will serve.
14. Number of Others Living in the Facility: Complete only if requesting service category *.5600F or .5100-Private Home Respite*. Include the number and ages of anyone that lives in the facility that is not a client.
15. Ambulatory/ Non Ambulatory Beds: Complete only if you are requesting a change of Ambulatory Beds to Non Ambulatory Beds.

**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 |

## 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:
**NC Division of Health Service Regulation**

**Send Application with required information to:**
Division of Health Service Regulation
MH Licensure & Certification Section
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**
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## Change Application Checklist

Incomplete applications will be returned to 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 prior to submitting your license application

**Requirements for 24-hour Residential Programs—Existing Structures**

**Note:** Before 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.

In addition to your cover letter and application please submit the following:

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. Location of all smoke detectors noting whether they are battery operated, wired into the house current with battery backup, and if they are interconnected.
2. Exterior photos of each side of the building.
3. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
4. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
5. **Local Zoning Department approval** for the proposed use**.**
6. Letter of support from LME/MCO (Only required when changing Counties)
7. Appointments for Fire & Sanitation Inspections.

### Change of Location Checklist: **Residential**

| | **Item** | **Completed** |
|---|---|---|
| 1 | Completed Change Licensure Application (form DHSR 5002) | |
| 2 | Floor Plan Identifying all spaces in facility<br>(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)<br>*Required for application to move forward* | |
| 6 | LME-MCO Support Letter<br>*****Only needed if location change is in a different county then the facility is currently located. | |
| 7 | Appointments for Fire & Sanitation Inspections.<br>Actual inspections are not needed when submitting the application but will be needed prior to DHSR Construction section approval. | |

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**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.

In addition to your cover letter and application 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. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
4. Local Zoning Department approval or verification the facility is classified under building/planning for 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 Officials 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 facility<br>(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)<br>*Required for application to move forward* | |
| 6 | Fire & Sanitation Inspections.<br>(Sanitation inspection only needed if 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).

# N.C. Department of Health and Human Services

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## CHANGE LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

**TYPE OF CHANGE:** **FACILITY MHL#:**_____

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

**Note:** *Change of Location & Change of Capacity require a Construction Fee. You will be invoiced for these fees. Do not send money for Construction Section when submitting this application. 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 change(s) 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: _____

Name: _____ Title: _____

Signature: _____ Date: _____

5. **SIGNATURE OF REQUESTED 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: _____

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

OFFICIAL USE ONLY: DHSR Form 5002

Licensure Categories: _____
Licensure Recommendation:_____ DHSR Consultant:_____
Remarks: _____

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## REQUESTED CHANGES

Requested Effective Date of Change: _____

* Please note, this is ***requested*** date of change, there is no guarantee the change will be completed by this date.

**In application pages 7 – 11, please complete *ONLY* those changes being requested.**

1. **FACILITY NAME:** _____
   * Name which the 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

2. **NEW 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 installed and operable prior to licensing; *cannot* be a cell phone.

3. **FACILITY CORRESPONDENCE MAILING ADDRESS:**

Name of Contact Person: _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Phone: _____Email:_____

Email Address (to which all correspondence will be sent)

**4. NAME OF FACILITY DIRECTOR :**( First, MI, Last)_____

**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: (First, MI,Last)_____

Signature: _____Title:_____ Date:_____

**6. MANAGEMENT COMPANY:** If 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:**

Full legal name of individual, partnership, corporation or other legal entity, which 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 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 health care 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 1-800-465-3203 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
_____ Corporation _____ Limited Liability Company
_____ 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%.

Shareholder Name: ( First, MI, Last) _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: ( First, MI, Last) _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

Shareholder Name: ( First, MI, Last) _____

Street Address: _____

City: _____State:_____ Zip Code: _____

Phone: _____ Email: _____

Percentage interest in this facility: _____Title: _____

**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

**10. 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 _____**

| Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities | Check Service of License | Beds Assigned by Age | | |
|---|---|---|---|---|
| | | 0-17 | 18 & up | Total Beds |
| .1100 Partial hospitalization for individuals who are acutely mentally ill. | | | | |
| .1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness | | | | |
| .1300 Residential treatment facilities for children or adolescents—Level II (Max. of 12 clients) | | | | |
| .1400 Day treatment for children and adolescents with emotional or behavioral disturbances | | | | |
| .1700 Residential treatment Staff Secure for Children or Adolescents—Level III | | | | |
| .1800 Intensive residential treatment for children or adolescents (Level IV) | | | | |
| .1900 PRTF – Psychiatric Residential Treatment Facility for minors who are emotionally disturbed or who have a mental illness. | | | | |
| .2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON Required) | | | | |
| .2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development | | | | |
| .2300 Adult Developmental and vocational programs for individuals with developmental disabilities | | | | |
| .3100 Non-hospital medical detoxification for individuals who are substance abusers | | | | |
| .3200 Social setting detoxification for substance abuse | | | | |
| .3300 Outpatient detoxification for substance abuse | | | | |
| .3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON Required) | | | | |
| .3600 Outpatient narcotic addiction treatment (preliminary SOTA Authorization letter required) | | | | |
| .3700 Day treatment facilities for individuals with substance abuse disorders | | | | |
| .4100 Therapeutic homes for individuals with substance abuse disorders and their children (min. 3 clients) | | | | |
| .4300 A supervised therapeutic community for individuals with substance abuse disorder | | | | |
| .4400 Substance Abuse Intensive Outpatient Program | | | | |
| .4500 Substance Abuse Comprehensive Outpatient Treatment Program | | | | |
| .5000 Facility based crisis service for individuals of all disability groups | | | | |
| .5100 Community respite services for individuals of all disability groups | | | | |

| Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities | Check Service of License | Beds Assigned by Age | | |
|---|---|---|---|---|
| | | 0-17 | 18 & up | Total Beds |
| .5200 Residential therapeutic (habilitative) camps for children and adolescents of 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. | | | | |
| 5600**A** Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients) | | | | |
| 5600**B** Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) | | | | |
| .5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) | | | | |
| .5600**D** Group homes for minors with substance abuse problems | | | | |
| .5600**E** Half-way houses for adults with substance abuse problems | | | | |
| .5600F Alternative family living – providing service in own private residence (Max. 3 clients) | | | | |

**11. DO YOU HAVE A CERTIFICATE OF NEED?** Required for the following service categories: .2100, .3400, & .5600 (only when ICF/IID facility)

☐ No Yes ☐ If yes, CON Number: _____ Date CON Received: _____

**12. 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

**13. NUMBER OF BEDS:**

| Type | Current License | Requested Change |
|---|---|---|
| Ambulatory* | | |
| Non-Ambulatory, 1-3 | | |
| Non-Ambulatory, 4 or more | | |

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

**14. NUMBER AND AGE(S) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:**
(Applicable only in categories where private residence is allowable: .5600 F & .5100 Private Home Respite)

_____

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

## CONSTRUCTION: PHYSICAL PLANT

**Please fill in EACH inspection Department information if 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 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 ☐

**N.C. Department of Health and Human Services**
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# 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 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<br>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 requires CON |
| j | Program is for women and their children. Usually in apartment/motel situation but if less that 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 is with another residential program. 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***.