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

Initial
Licensure Application Packet

Form# DHHS/DHSR/MHL5001
Revised 08/29/2018

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

Memorandum

To: Mental Health, Developmental Disabilities, and Substance Abuse Facility Licensure Applicants
From: Mental Health Licensure and Certification Section
Re: Initial Licensure Application Packet

You may find helpful information regarding how to establish a mental health facility including frequency asked questions and different service categories we license on our website at https://www2.ncdhhs.gov/dhsr/mhlcs/establish.html.

Enclosed you will find an Initial Licensure Application Packet. The packet includes the following:

- Licensure Application Process
- Initial Licensure Application
- Photographs sheet
- MH Licensure Policies and Procedures Worksheets

The following rules are essential for all licensed mental health facilities to help formulate the required Operations and Management Policies, Guidelines and Procedures (download for free at http://www.ncdhhs.gov/dhsr/mhlcs/rules.html).

- 10A NCAC Chapter 26 Mental Health, General
  Subchapter C Other General Rules
- 10A NCAC Chapter 27 Mental Health, Community Facilities and Services
  Subchapter C Procedures and General Information
  Subchapter D General Rights
  Subchapter E Treatment or Habilitation Rights
  Subchapter F 24-Hour Facilities
  Subchapter G Rules for Mental Health, Developmental Disabilities, and Substance Abuse Facilities and Services

Hard copies of these rules can be ordered from the Division of MH/DD/SAS:

- Phone: (919) 715-2150
- E-mail: contactdmh@dhhs.nc.gov
- Mailing address: 3001 Mail Service Center, Raleigh NC 27699-3001
- Walk-in address: 306 N. Wilmington Street, Raleigh, NC.

The following NC General Statutes are essential for all licensed mental health facilities. This is not an all-inclusive list; a complete list of NC General Statutes that govern licensed facilities are found at http://www.ncleg.net/gascripts/Statutes/StatutesTOC.pl

- NC G.S. 122C 6: Smoking Prohibited
- NC G.S. 122C 63 Assurance for Continuity of Care for Individuals with Mental Retardation
- NC G.S. 122C 80 Criminal History; Record Check
- NC G.S. 131E 256 Health Care Personnel Registry

N.C. Department of Health and Human Services
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LICENSE APPLICATION PROCESS

An applicant must be able to complete all necessary requirements ***within 6 months*** from the initial application date to obtain a license. After initial licensure, the facility must have the license renewed every year.

In order to apply for a license from the Division of Health Service Regulation to operate a mental health facility as required under General Statute 122C, you must do the following:

1. Complete the application
   (a) 24-hour Residential Programs:
   - Take the completed application (pages 9-14) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Take the completed application (pages 9-14) to your area Local Management Entity-Managed Care Organization (LME-MCO) office and obtain a Letter of Support as per 10A NCAC 27G .0406. Attach LME-MCO support letter to the application. A Letter of Support is not required for services that have a Certificate of Need (CON) from DHSR, which currently includes service category .3400 and ICF/IID facilities.
   - Submit all items listed in **Requirements for 24-hour Residential Programs** box on page 7.
   - Include initial licensure fee upon submitting all items.

   (b) Day Programs:
   - Take the completed application (pages 9-14) to your local zoning office and obtain zoning approval. Attach the zoning approval letter to the application.
   - Preliminary program approval letter is required from State Opioid Treatment Authority (SOTA) for all service category 3600 facilities.
   - Submit all items listed in **Requirements for Day Programs** box on page 8, including approved Fire Marshal, Sanitation and Building Officials inspection reports as required.
   - Include initial licensure fee upon submitting all items.
2. Write a letter briefly describing the services to be offered by the facility.
3. Develop written policies and procedures for your service, but do not submit them with the application, as they will be reviewed at a later date.
4. Make check payable to: **NC Division of Health Service Regulation**
5. 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

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

N.C. Department of Health and Human Services

Division of Health Service Regulation
Mental Health Licensure and Certification Section
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Building Code Zoning Classifications - Requirements for Licensure Categories (revised 8-8-2013)

Program Code 10 NCAC 27G	Facility Type	Residential/ Institutional 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 I4 (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 I4 (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 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 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 is a resident with another residential program. Could be part of a larger facility 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.

License Fees: Initial License & Construction

All licensed facilities, residential and non-residential are required to pay an initial license and annual license renewal fee. NC General Statute 122C-23:

- Prohibits the issuance of the license until the license fee is paid.
- Mandates that licenses must be renewed annually and will expire at the end of the calendar year.

Please submit Licensure fee with the application. Do not submit the Construction fee. Our Construction section will bill you for the applicable fee prior to conducting their site visit.

Initial Licensure Fee NC General Statute 131E-272: Following is a list of types of facilities with required 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	$265.00	N/A
Residential Facilities (Non-ICF/IID)	6 beds or less	$350.00	$0
Residential Facilities (Non-ICF/IID)	7 beds or more	$525.00	$19.00
ICF/IID* Facilities	6 beds or less	$900.00	$0
ICF/IID* Facilities	7 beds or more	$850.00	$19.00

*ICF/IID: Intermediate Care Facility for Individuals with Intellectual Disabilities, a specialized Medicaid facility requiring a Certificate of Need from the DHSR Certificate of Need Section.

Construction Fees: In addition to the license fee, 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

Contact Information

For questions regarding any part of this process, please contact the appropriate section of the Division of Health Service Regulation or visit our website www.ncdhhs.gov/dhsr/

Mental Health Licensure and Certification Section	919-855-3795
Construction Section	919-855-3893

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

License Application Requirements & Checklists

Incomplete applications will be returned to sender, without processing, accompanied by a letter explaining the incorrect or missing information. Please complete the appropriate checklist 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, application, and fee, please submit the following:

1. A floor plan that specifies the following:
2. All levels including basements and upstairs.
3. Identification of the use of all rooms/spaces.
4. Dimensions of all bedrooms, excluding any toilets, bathing areas and closets. Clarify double or single occupancy.
5. Location of all doors and the dimensions of all exterior doors.
6. Location of all windows including the dimensions of bedroom windows and sill height of bedroom windows above the finished floor.
7. Location of all smoke detectors noting whether they are battery operated, wired into the house current with battery backup, and if they are interconnected.
8. Exterior photos of each side of the building.
9. Interior photos of the kitchen, living areas, bedrooms, and any other rooms.
10. Directions from Raleigh or a map from the nearest major highway, street or intersection clearly showing the location of the facility.
11. **Local Zoning Department approval** for the proposed use**.**
12. Letter of support from LME/MCO. Not required for ICF-IID facilities or 10A NCAC 27G .3400.
13. Certificate of Need: Required for any new ICF/IID facilities or 10A NCAC 27G .3400.
14. Appointments for Fire & Sanitation Inspections.

24-Hour Residential Checklist

	Item	Completed
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 5001)	
3.	Fee	
4.	Floor Plan Identifying all spaces in facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
5.	Pictures (Interior & Exterior)	
6..	Directions to Facility	
7.	Zoning Approval (original) *Required for application to move forward*	
8.	LME-MCO Support Letter if not ICF-IID or 10A NCAC 27G .3400.	
9.	Certificate of Need: If ICF-IID Facility or 10A NCAC 27G .3400	
10.	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

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, application, and fee, 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.

Day Program Checklist

	Item	Completed
1.	Cover Letter	
2.	Completed Initial Licensure Application (form DHSR 5001)	
3.	Fee	
4.	Floor Plan with dimensions	
5.	Pictures (Interior & Exterior)	
6.	Directions to Facility	
7.	Zoning Approval (original) ***Required for application to move forward***	
8.	Fire Inspection (clear copy or original)	
9.	Sanitation Inspection (clear copy or original) if serving food	
10.	Preliminary Program approval from SOTA (service category 3600)	
11.	Building Inspection (original) if applicable for new construction or renovation of building	

N.C. Department of Health and Human Services
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INITIAL LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

Include First Name, Middle Initial & Last Name for ***every person*** listed in application

Office use only: ***License Number:*** **MHL#**_____ **FID#** _____

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. **FACILITY SITE ADDRESS: (NO P.O. BOXES)**

Street Address: _____

City: _____State: _____Zip Code: _____

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:_____

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:_____

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

OFFICIAL USE ONLY: DHSR Form 4080

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

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, PRINCIPLES, AFFILIATES, SHAREHOLDERS (Confidential Information for Official Use Only)

For-Profit Individuals or Companies

Complete the information below on **all** individuals who are owners, principles, affiliates or shareholders holding an interest of 5% or more of the licensing entity listed on page 2. Attach additional pages if necessary. 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 licensing entity 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 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.

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 hospitalizations 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 (Max of 12 clients)				
.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 if ICF/IID)				
.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				

Rule 10A NCAC 27G Licensure Rules for Mental Health Facilities	Check Service of License	Beds Assigned by Age 0-17	18 & up	Total Beds
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community Respite services for individuals of all disability groups				
.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 – NOTE: Only *one* category (A, B, C, D, E or F) can be checked for .5600 facilities				
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) (CON required only if ICF/IID)				
.5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients) (CON required only if ICF/IID)				
.5600**D** Group homes for minors with substance abuse problems				
.5600**E** Half-way houses for adults with substance abuse problems				
.5600**F** Alternative family living – providing service in own private residence (Max. 3 clients)				

11. DO YOU HAVE A CERTIFICATE OF NEED? *Required* for ICF/IID Facilities (program code .2100 or .5600C) and .3400 facilities

☐ 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: http://www.ncdhhs.gov/dhsr/ahc/clia/index.html

13. NUMBER OF CLIENTS FOR WHICH THE FACILITY IS GOING TO BE LICENSED:

Type	**Specify Number to be Licensed**
Ambulatory*	
Non-Ambulatory, 1-3	
Non-Ambulatory, 4 or more	

*Ambulatory: A person who can evacuate the facility 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: .5600F & .5100 Private Home Respites)

_____

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

PHYSICAL PLANT

Please fill in information for **each** inspection Department:

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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Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

PHOTOGRAPHS

Name of Facility: _____

County: _____

Please attach photos of your facility, as required, to this sheet and add other blank sheets as needed. **Please label each photograph as to identity of room** within the facility and **also <u>on</u>** the **<u>back of the photo identify</u> with the name and address of the facility** (to help identify picture should they get separated) Thank you.

MH Licensure Policies and Procedures Worksheets

The following form is a tool designed to help the MHL&C initial surveyor while reviewing the agency's policy & procedure manual. The information below is only a snapshot of the actual rules and *is not* a substitute for obtaining the licensure rule book. Providers are welcome to use the form as a tool if desired but it is not a requirement.

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Policies & Procedures: Initial Licensure Survey

Important Note: This form is a tool designed to help the MHL&C initial surveyor while reviewing the agency's policy & procedure manual. The information below is only a snapshot of the actual rules and *is not* a substitute for obtaining the licensure rule book. Providers are welcome to use the form as a tool if desired but it is not a requirement.

Facility Name:		MHL#:		10NCAC 27G Licensure Code(s):			
County:		Date:		Time Begin:		Time End:	
Consultant Name:				Type of survey (initial or change):			

Section 10A NCAC 27G .0200 Operation and Management Rules

10A NCAC 27G .0201: Governing Body Policies

☐ **Delegation of Management Authority**	☐ **Admission Criteria**	☐ **Discharge Criteria**
☐ **Who Will Perform Assessments**	☐ **Assessment Time Frame**	☐ **Persons authorized to document in ct record**
☐ **Transporting Records**	☐ **Safeguarding of Records**	☐ **Accessibility of records to Authorized Persons**
☐ **Assurance of Confidentiality of Records**	☐ **Assessment of Presenting Problem**	☐ **Assessment of Ability to Provide Service(s)**
☐ **Disposition of Ct(s)**	☐ **QA/QI Activities and Composition**	☐ **Written Plan for QA/QI**
☐ **Methods of Monitoring Ct Care**	☐ **Qualified Supervision**	☐ **Intervention Advisory Committee**
☐ **Strategies for Improving Ct Care**	☐ **Staff Credentialing/Privileging**	☐ **Review of Fatalities**
☐ **Standards of Practice**	☐ **Incident Reporting**	☐ **Medication Usage (27G .0209 for detailed list)**
☐ **Voluntary Non-Compensated Ct Work**	☐ **Fee Assessment & Collection**	☐ **Medical Emergency Plan**
☐ **Authorization for Follow Up of Lab Tests**	☐ **Transportation**	☐ **Safety Precautions (Fire/Disaster Plan)**
☐ **Volunteers: Confidentiality Requirements**	☐ **Staff Training & CEU's**	☐ **Ct Grievance Policy**
☐ **Infectious Disease (identify, control, report, investigate)**		

10A NCAC 27G .0203: Competencies of Qualified and Associate Professionals

☐ **Initiation of individualized supervision plan upon hiring each associate professional**

10A NCAC 27G .0204: Competencies and Supervision of Paraprofessionals

☐ **Initiation of individualized supervision plan upon hiring each paraprofessional**

10A NCAC 27G .0209 Medication Requirements

☐ **Meds dispensed only by written MD order**	☐ **Dispensing of meds only by Licensed Person**	☐ **Take home Methadone given to ct by RN only**
☐ **Facilities shall not keep prescription drugs for dispensing without a Pharmacist, except for emergency use. A small supply of samples may be kept and locked by MD**	☐ **Non-Prescribed drug containers not dispensed by a Pharmacist must have original label with expiration dates visible.**	☐ **Prescription meds must be dispensed in tamper resistant packaging**
☐ **Label on prescription meds must include: Ct name; MD name; dispensed date; administration directions; name, strength, quantity & expiration date of drug; name & address of Pharmacy; name of Pharmacist**	☐ **Meds administered by written MD order**	☐ **Meds self administered only on with written MD order**
☐ **Med administration only by trained staff**	☐ **6 month drug review by a Psychiatrist or Pharmacist required if taking Psychotropic meds**	☐ **Findings from drug review recorded in ct record with corrective action plan**
☐ **Staff is responsible for informing MD of review results if medical intervention is indicated**	☐ **Meds prescribed by an area program MD will give written or oral instructions**	☐ **Med education will be enough to allow for ability to make informed consent**
☐ **The area program will have written documentation in ct record that education was given, to whom & in what format**	☐ **Ct request for med changes/checks on MAR**	☐ **Non-controlled meds must be disposed of by flushing or returning to pharmacy**
☐ **Controlled meds must be disposed of by the rules in NC controlled Substance act G.S. 90**	☐ **Documentation of disposal in record with ct name, med name, strength, quantity, disposal date & method, signature of disposer & witness**	☐ **Upon ct discharge, meds shall be disposed of immediately**
☐ **Meds must be locked**	☐ **Refrigerated meds must be in separate locked container**	☐ **Meds must be stored separately for each ct**
☐ **Meds must be stored separately for internal & external use**	☐ **Meds must be stored in a secure place for ct approved to self-administer**	☐ **A facility must be registered under G.S. 90, article 5 if controlled substances are on premises**
☐ **MAR must be kept current**	☐ **MAR must include: ct name, name, strength & quantity of drug; instructions for administration; date & time of administration; initials of person administering med**	☐ **Med errors are to be recorded in MAR**
☐ **Med refusal or adverse reactions are to be recorded**	☐ **Severe reactions to be immediately reported to MD or Pharmacist**	

Notes:

Section 10A NCAC 27D Client Rights in Community Mental Health, Developmental Disabilities & Substance Abuse Services

10A NCAC 27D .0101 Policy on Rights Restrictions and Interventions

☐ **Alleged/suspected abuse/neglect/exploitation reported to are DSS**	☐ **Safeguards are used when meds present an increased risk to ct (i.e. neuroleptics)**	☐ **Identify prohibited restrictive interventions (RI)**
☐ **24hr facility: Identify circumstances when staff cannot restrict the rights of cts**	☐ **Identify allowed RI**	☐ **Staff responsible for informing ct**
☐ **Due process procedure for ct refusing RI**	☐ **Identify staff responsible for giving written permission for 24hr RI**	☐ **Identify staff responsible for review of RI**

☐ **Process of appeal for disagreement over planned use of RI**	☐ **Ct's physical and psychological well-being to include: review of cts health history or comprehensive health assessment; continuous assessment & monitoring of the ct's physical/ psychological well being throughout the duration of RI; continuous monitoring of the ct's physical/psychological well being by a staff training in CPR; and continuous monitoring of the ct's well being for a minimum of 30 minutes by a staff trained in CPR**	☐ **Following the use of RI, the staff shall conduct a debriefing and planning with the ct and legally responsible person. This process should be conducted based on the cognitive functioning of the ct.**

10A NCAC 27D .0102 Suspensions and Expulsion Policy

☐ No ct shall be threatened w/unwarranted suspension or expulsion	☐ **Policy & criteria for suspension**	☐ Time and conditions for resuming services
☐ Documentation of efforts to make alternative services available	☐ Discharge Plan, if any	

10A NCAC 27D .0103 Search and Seizure Policy

☐ Ct should have privacy	☐ **Policy on search/seizure of ct's possessions (including circumstances)**	☐ Documentation of search/seizure including: Scope, search, reason, procedures followed, account of disposition of seized property

10A NCAC 27D .0104 Periodic Internal Review

☐ Facility shall conduct a review at least every 3 years to check for compliance with applicable laws	☐ The governing body will keep the last 3 written reports of the findings of the reviews

10A NCAC 27D .0201 Informing Clients

☐ Written client rights given to ct or guardian	☐ Each ct must be informed of right to contact Governor's Advocacy Council	☐ Documentation in record that rights were explained
☐ Within 72 hours or three visits, ct will be informed of rules and violation penalties; disclosure rules for confidential info; procedure for obtaining a copy of treatment plan; grievance procedure (including contact person); suspension/expulsion and search and seizure		

☐ In facilities using RI: within 72 hours or 3 visits, ct will be informed of the purpose, goal & reinforcement structure of a behavior management system; potential restrictions; notification provisions regarding use; notice that the legally responsible person after use of a RI; a competent adult may designate an individual to receive information after RI and notification provisions regarding restriction of rights

10A NCAC 27D .0202 Informing Staff

☐ **Written policy on informing staff of ct rights**	☐ Documentation of receipt of information by each staff

10A NCAC 27D .0301 Social Integration

☐ Each ct will be encouraged to participate in activities	☐ Cts will not be prohibited from activities unless restricted in writing and in record

10A NCAC 27D .0302 Client Self Governance

☐ **Written policy allows ct input into facility governance & development of ct self governance groups**

10A NCAC 27D .0303 Informed Consent

☐ Ct will be informed about the alleged benefits, potential risks and alternative treatments	☐ Ct will be informed about the length of time the consent is valid and procedure to withdraw consent	☐ Consent for use of RI valid for 6 months
☐ Written consent needed for planned interventions	☐ Written consent needed for antabuse & Depo-Provera, when used for non FDA approved uses	☐ Cts have a right to refuse treatment, shall not be threatened with termination
☐ Documentation of informed consent in ct record		

10A NCAC 27D .0304 Protection from Harm, Abuse, Neglect or Exploitation

☐ Staff will protect clients from harm, abuse, neglect and exploitation	☐ Staff will not inflict harm, abuse, neglect or exploit ct	☐ Goods/services will not be sold to or purchased from ct except through established policy
☐ Staff will only use the degree of force necessary to repel or secure a violent/aggressive ct and which is permitted by the policies. The degree of force necessary depends on the characteristics of the ct and the degree of aggressiveness. Use of interventions in agreement with 10A NCAC 27D		☐ Any violation of this rule by staff is grounds for dismissal

Notes:

Section 10A NCAC 27E Treatment of Habilitation Rights

10A NCAC 27E .0100 Protection Regarding Intervention Procedures

☐ If the Facility uses Seclusion, Restraints and Isolation Time Out this section must be checked in the rulebook and must be reflected in the facility's policy and procedure manual.

10A NCAC 27E .0101 Least Restrictive Alternative

☐ Facilities shall provide services using the least restrictive, most appropriate and effective positive treatment policy	☐ The use of RI to reduce a behavior will be used with positive treatment or habilitation methods	☐ Treatment methods shall include: deliberative teaching & reinforcement of behaviors which are non-injurious; improvement of conditions associated with non-injurious behaviors (i.e. enriched social and educational environment); alteration or elimination of environments conditions correlated with self injury

10A NCAC 27E .0102 Prohibited Procedures

☐ The following procedures are prohibited: corporal punishment; painful body contact; substances which create painful bodily reactions; electric shock; insulin shock; unpleasant tasting foodstuffs; application of noxious substances (noise, bad smells, splashing with water); physically painful procedures to reduce behavior	☐ The governing body may determine to prohibit use of any interventions deemed unacceptable

10A NCAC 27E .0103 General Policies Regarding Intervention Procedures

☐ The following procedures can only be used when clinically/medically indicated as a method of treatment: planned non-attention to specific undesirable behaviors when they are health threatening; contingent deprivation of any basic necessity or professionally acceptable behavior modification procedures not prohibited by rules .0102 or .0104	
☐ The determination that a procedure is clinically/medically indicated and the authorization for use of such treatment for a specific ct can only be made by a physician or a licensed PHD who has been formally trained and privileged in the use of a procedure.	

10A NCAC 27E .0104 Seclusion, Restraint and Isolation Time Out

☐ Use of RI shall be limited to emergency situations (to terminate dangerous behavior) or as a planned measure of therapeutic treatment	☐ RI will not be used as retaliation or convenience of staff & will not cause harm
☐ **Written policy delineates use of RI**	☐ **Written policy when RI is used must be written and approved by the Commission and must follow rules 27E .0104(e)(1)(A-D) or the facility must have provisions included in the next box**
☐ (e)(2) Review of ct's health history or ct's comprehensive health assessment conducted upon admission to the facility. The assessment shall include pre-existing medical conditions or any disabilities and limitations that would pout the ct at risk during the RI; continuous assessments and monitoring of the ct's physical and psychological well being throughout the duration of the RI by a staff present and trained in RI; continuous monitoring of the ct's physical and psychological well being by a staff trained in CPR during the use of the restraint and continued monitoring of the ct's physical and psychological well being by a staff trained in CPR for a minimum of 30 minutes to the termination of RI	
☐ If the facility complies with (3) (2) then the following provisions apply: and room used for seclusion will comply with 8(A-I).	☐ When a ct is in seclusion or physical restraint they must be observed ≤ 15 minutes; ct will be allowed meals, bathing and toilet use; both of which must be recorded in the ct record
☐ When RI is used documentation in the ct record will include: notation of the ct's physical and psychological well being, notation of the frequency, intensity & duration of behavior leading to the RI and circumstances leading to the behavior; rationale for using RI which addresses the inadequacy of less restrictive techniques; description of intervention and date time & duration of use; description of accompanying positive methods of intervention; a description of the debriefing and planning with the ct and legal responsible person for the emergency use of seclusion, physical restraint or isolation time out; a description of the debriefing and planning with the ct and the legal responsible person for the planned use of seclusion, physical restraint or isolation time out; a signature & title of the staff who initiated and the staff who further authorized the use of the intervention	
☐ Emergency use of RI will be limited to : staff privileged to use RI based on experience & training; continued use of interventions will be authorized only by staff privileged to use RI; the responsible staff will meet with and conduct an assessment that includes the physical and psychological well being of the ct and write continuation authorization ASAP after the time of initial use of intervention; verbal authorization can be five if responsible staff concurs that it is justified; verbal authorization will not exceed 24 hours; and a written order for seclusion, physical restraint or isolation timeout is limited	
☐ When RI is used as planned intervention the facility policy shall specify consent or approval valid for no more that 6 months based on recent behavioral evidence intervention is positive and continues to be needed	☐ When ct is in isolation time out there will be staff solely to monitor ct, there will be continued visual and verbal interaction which will be documented in the ct record

☐ RI will be discontinued ASAP or within 30 minutes of behavior control, new authorization must be obtained for RI over 30 minutes to four hours for adult cts; two hour for children and adolescents ages 9 – 17; one hour for cts under age 9. The original order shall be renewed with these limits or up to a total of 24 hours.		
☐ Written approval required for RI exceeding 24 hours	☐ Standing orders or PRN orders shall not be used to authorize the use of RI	☐ When ct is in physical restraint staff will remain with the ct continuously
☐ Documentation of RI must be in ct record. When RI issued notification to the treatment team & designee of the governing body must occur ASAP or within 72 hours	☐ Review and report of RI must be conducted regularly; investigations of unusual or unwarranted patterns of utilization	
☐ Documentation shall be maintained on a log including: Name of ct; name of responsible staff; date, time type, duration, reason for intervention, positive and less restrictive alternative used or considered and why used, debriefing and planning conducted to eliminate or reduce the probability of future use of RI and negative effects of RI on the physical and psychological well being of the ct	☐ The facility shall collect and analyze data on the use of seclusion and restraining on the following: the type of procedure used and length of time employed; the alternatives considered or employed; and the effectiveness of the procedure or alternative employed	
☐ RI can be considered a planned intervention and will be included in the ct's treatment plan when used: ≥ 4X or ≥ 40hrs in 30 consecutive days; in a single episode for ≥24 continuous hrs in an emergency; or as a measure of therapeutic treatment designed to reduce behavior to allow less restrictive treatment		
☐ When RI is used as a planned intervention the facility policy shall specify consent or approval valid for no more that 6 months based on recent behavioral evidence intervention is positive and continues to be needed	☐ Prior to initiation or continued used of planned RI, written consent/approval in ct record – approval of plan by professional and treatment team, consent of ct or legally responsible person, notification of ct advocate, and physician approval	
☐ Documentation in ct record regarding use of planned intervention shall indicate: description and frequency of debriefing. Debriefing shall be conducted to the level of functioning of the ct; bi-monthly evaluation of the planned intervention by the responsible professional; and review at least monthly by the treatment/habilitation team that approved the planned intervention		
☐ Ct's are able to request voluntary RI		

10A NCAC 27E .0105 Protective Devices

☐ When protective devices are used, a written policy will ensure that: the need has been assessed and the device applied by staff trained and privileged to do so; it is the most appropriate treatment; the ct is frequently observed and given opportunity to use the toilet, exercise and is monitored every hour	☐ Documentation and interventions will be recorded in ct record	☐ Protective devices are to be cleaned regularly
☐ Facilities operative by or under contract with an area program will be subject to review by the ct rights committee	☐ Use of devices will comply with 27E .0104	

10A NCAC 27E .0106 Intervention Advisory Committees (only if RI are used)

☐ An Intervention Advisory Committee will be established to provide additional safeguards in a facility using RI	☐ The Intervention Advisory Committee should have at least one member who has been a member of direct services or a close relative of a consumer and: for an area program facility the Committee will be the ct rights committee; in a facility not operated by an area program, the Committee will be the Human Rights Committee; or a facility will have a committee will have 3 citizens who are not employees of members of the governing body	☐ Intervention Advisory Committees shall have a member or regular independent consultant who is a professional with training and expertise in the use of the type of interventions who is not directly involved with the treatment of the ct
☐ The Intervention Advisory Committee will have a policy that governs the operations and states that ct information will only be given to committee members when necessary to perform duties	☐ Intervention Advisory Committee will receive specific training and orientation, be provided with copies of related statutes and riles, maintain minutes of each meeting, and make an annual written report to the governing body on activities of the committee	

10A NCAC 27E .0201 Safeguards Regarding Medications

☐ Use of experimental drugs is research and will be governed by GS 122c-57(f)	☐ Use of other drugs as treatment measure shall be governed by GS 122c-57, GS 90 Articles 1, 4A and 9A

Notes:

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Policies & Procedures: Initial Licensure Survey

Section 10A NCAC 27F Specific Rules for 24-Hour Facilities

10A NCAC 27F .0101 Scope

☐ Article 3, Chapter 122C of the General Statues provides specific rights for each ct who receives a mental health, developmental disability or substance abuse service. This subchapter delineates the rules regarding those rights for cts in a 24-hour facility	

10A NCAC 27F .0102 Living Environment

☐ Efforts to make a quite atmosphere for uninterrupted sleep, privacy areas	☐ Ct may suitably decorate room, when appropriate

10A NCAC 27F .0103 Health, Hygiene and Grooming

☐ Ct will have the right to dignity, privacy and humane care in healthy hygiene and grooming	☐ Cts will have access to shower/tub daily or more often as needed; access to a barber or beautician, access to linens and towels and other toiletries
☐ Adequate toilets, lavatory and bath facilities equipped for use by a ct with a mobility impairment will be available	☐ Ct bathtubs, showers and toilets will be private

10A NCAC 27F .0104 Storage and Protection of Clothing and Possessions

☐ Staff will make every effort to protect ct personal clothing and possessions from loss or damage

10A NCAC 27F .0105 Client's Personal Funds

☐ Each ct will be encouraged to maintain funds in a personal account	☐ Funds managed by staff will: assure ct right to deposit and withdraw money; regulate the receipt and distribution, and deposits of funds; provide adequate financial records on all transactions; assure ct funds are kept separate; allow deduction from accounts for payment of treatment/habilitation services when authorized; issue receipts for deposits and withdrawals provide ct quarterly statements	☐ Authorization by ct required before a deduction can be made from an account for any amount owed for damages done by the ct to the facility, to an employee of the facility, a visitor or another ct.

Section 10A NCAC 13O Healthcare Personnel Registry

10A NCAC 13O .0102 Investigating and Reporting Health Care Personnel Registry

☐ The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).