Health and Human Services

Substance Use Disorder and Problem Gambling Treatment Program

License Revision Application

Introduction

Iowa Code Chapter 125 requires substance use disorder treatment programs to be licensed by the Iowa Department of Health and Human Services (Department). Iowa Code section 135.150 requires gambling treatment programs funded through the Department to be licensed by the Department. The Department implements its program licensure duties through 641−Iowa Administrative Code Chapter 155.

Please review all instructions carefully.

Pursuant to IAC 641—155.5(2) and 155.17, a licensee shall submit a written request to the division to revise a license at least 30 days prior to any change of address, executive director, clinical oversight staff, facility, or licensed services. For significant changes to currently licensed programs, a license revision application shall be submitted at least 90 days before the expiration of the current license or before the program change.

Direct all application questions at SUD.PG.License@hhs.iowa.gov.

Complete and electronically sign the Program License Revision Application Form and submit it and all required materials to the Department as follows:

Via email sent to SUD.PG.License@hhs.iowa.gov.

The License Revision Application Form contains six areas of information, each of which must be completed in detail. The six areas in the instructions below correspond to the six areas in the License Revision Application Form.

1. **Applicant Information:**

   Specify the revision to the official name of the applicant program and Director. Specify the program telephone number, fax number, and e-mail address.

   If applicable, check the type of license for which the applicant is requesting changed

   If the applicant is part of a larger organization, provide the name and address of the larger organization and Organization Director.

2. **Licensed Program Services:**

   Indicate the licensed program service for which a revision is being made. Provide bed capacity where indicated.

3. **Facilities:**

   Give the names, addresses, contact information and hours of operation for ALL program facilities where licensed SUD/PG services are being added or changed including schools, shelters, jails, etc. Submit as an attachment if more space is needed.

4. **Staff**:**

   Additional staff to be added as a result of the revision (if staff have not been hired, indicate the job title for each open position):

   - Provide names, titles, and dates of employment, type of license or certificate (if appropriate), and staff type for all staff with whom program patients have direct contact.
   - Provide a list of any licensed or credentialed staff that have been sanctioned or disciplined by a certifying or licensing body, including the name of the staff member, the sanction or discipline imposed, the date and nature of the sanction or discipline and the name of the certifying or licensing body, since the previous renewal of the license.

   **"Staff" means any individual who conducts an activity on behalf of a program as an employee, agent, consultant, contractor, volunteer, support staff or other status.

5. **Policies and Procedures:**

   Submit additional Policies and Procedures that have been updated, revised or created as a result of the future change in your program.

6. **Revision Date and Signature:**

   Provide the anticipated date for the revision to take effect and the signature of Program Executive Director or Designee.

License Revision Application Form

1. Licensee Information

Program Information

Program Name:

This will be used for the license certificate

Does the revision request include a change in program name? ☐ Yes ☐ No

Executive Director's Name:

Does the revision request include a change in leadership? ☐ Yes ☐ No

If Yes, please describe the change:

Administrative Office Address:		
City:	State:	Zip Code:
Telephone:	Fax:	
Email:		
Applying for License as:	☐ Substance Use Disorder Assessment and OWI Evaluation-only Program ☐ Substance Use Disorder Treatment Program ☐ Problem Gambling Treatment Program ☐ Substance Use Disorder and Problem Gambling Treatment Program	

If Applicant is part of a larger organization

Organization Name:		
Organization Director's Name:		
Address:		
City:	State:	Zip Code:
Email:	Telephone:	Fax:

2. Licensed Program Services for which revision is being made

☐ **Substance Use Disorder Assessment and OWI Evaluation only**, provided by a Substance Use Disorder Assessment and OWI Evaluation-only Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

☐ **Outpatient Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

☐ **Intensive Outpatient Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

☐ **Partial/Day Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

☐ **Clinically Managed Low-Intensity Residential Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

Capacity: ☐

Adult male	Juvenile male	Adult female	Juvenile female

☐ **Clinically Managed Medium-Intensity Residential Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

Capacity: ☐

Adult male Adult female

Is this an addition or removal?

☐ **Clinically Managed High-Intensity Residential Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Bed capacity: _____ Is this an addition or removal?

Adult male	Juvenile male	Adult female	Juvenile female

☐ **Medically Monitored Intensive Inpatient Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Bed capacity: _____ Is this an addition or removal?

Adult male	Juvenile male	Adult female	Juvenile female

☐ **Medically Managed Intensive Inpatient Treatment**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Bed capacity: _____ Is this an addition or removal?

Adult male	Juvenile male	Adult female	Juvenile female

☐ **Enhanced Treatment Services**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

☐ **Opioid Treatment Services**, provided by a Substance Use Disorder Treatment, Problem Gambling Treatment, or Substance Use Disorder and Problem Gambling Treatment Program.

☐ Adult services ☐ Juvenile services

Is this an addition or removal?

3. Facilities that are to be added or removed from the license (makes copies if needed)

Additional Facility Name:		
New Address:		
City:	State:	Zip Code:
Telephone:	Fax:	

Days and Hours of Operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Levels of care offered for adults:		
Levels of care offered for juveniles:		
Previous Facility Name (if applicable):		
New Address:		
City:	State:	Zip:
Telephone:	Fax:	

4. Staff

4.Additional staff to be added as a result of the revision (if staff have not been hired, indicate the jobtitle for each open position) Also use this section to include change in clinical oversight staff.

“Staff”means any individual who conducts an activity on behalf of a program as an employee, agent, consultant,contractor, volunteer or other status

Name	**Position** (i.e. job title)	**Start Date**	**End Date** *(if applicable)*	**Credentials** *(if applicable)*	**Staff Type** *(employee, contractor, agent, volunteer, etc.)*

Staff sanctioned or disciplined by a certifying or licensing body in the last three years:

Name of staff	Date of sanction	Sanction imposed	Name of Licensing or Certifying Body

5. Policies and Procedures Manual

Applicants must submit as attachment

- Any Policies and Procedures that have been created or revised as a result of the revision.

6. Revision Date and Signature

Anticipated date for vision: _____

_____ _____

Executive Director or Designee's Signature Date

_____

Executive Director or Designee Name (print)