



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

Change Licensure Application Packet

Form# DHHS/DHSR/MHL5002

Revised 11/15/2016

Mental Health Licensure and Certification Section

www.ncdhhs.gov/dhsr

Tel 919-855-3795 • Fax 919-715-8078

Location: Edgerton Building • 1800 Umstead Drive • Raleigh, NC 27603

Mailing Address: 2718 Mail Service Center • Raleigh, NC 27699-2718

An Equal Opportunity / Affirmative Action Employer



Instructions for Completing a Change Licensure Application

Overview

1. These instructions are provided to assist you in completing a change or renewal 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 Checklist (page 4).
 - Change of Capacity: If increase in capacity you must submit photos & floor plan.
 - 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 necessary in both #4 & #5. All signatures are required of owners of partnerships or equal shareholders. Add additional sheet if necessary for all signatures required approving the change. 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

In pages 4-10, 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 for the new address is in compliance.
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.

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

- (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 this is a non-profit entity, Signature and title and date needed in 1st box.
 - 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%. Social Security numbers are requested, but voluntary.
 - 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 whether or not 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: Physical Plant

Complete this section if a change in location.

1. Inspection Department information
2. Building Information.

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

1. Make check payable to: **NC Division of Health Service Regulation**
2. Send application with required information to:
 - Division of Health Service Regulation
 - MH Licensure & Certification Section
 - 2718 MSC
 - Raleigh, NC 27699-2718

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

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

Change of Location Checklist: Residential

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

Change of Location Checklist: Day Program

	Item	Completed
1	Completed Change Licensure Application (form DHSR 5002)	
2	Floor Plan Identifying all spaces in facility (all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)	
3	Pictures (Interior & Exterior)	
4	Zoning Approval (original – within 1 year of application date) <i>Required for application to move forward</i>	
5	Directions to Facility	
6	Fire & Sanitation Inspections. **Sanitation inspected 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 (see pages 13 & 14 of this application for requirements).

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

CHANGE LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF CHANGE:

FACILITY MHL#- _____ - _____

- Facility Name Capacity Service Category
- Ambulatory Bed(s) to Non Ambulatory Bed(s)

- Change of Licensee/ Owner**
- Location:
 - Within the Same County
 - Into a Different County

Other; Please Specify: _____

****Note:** Change in Ownership requires a license fee to accompany this application. 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.

CURRENT LICENSE INFORMATION (complete requested change(s) on following pages)

1. CURRENT FACILITY NAME: _____

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

Street: _____

City _____ Zip Code _____ County _____

*Facility Telephone Number (_____) Fax Number (_____)

*must be installed and operable prior to licensing-no cell phones.

3. CURRENT LEGAL IDENTITY OF OWNERSHIP/LICENSEE:

Name of Owner: _____

Address: _____ City _____ State: _____ Zip Code _____

Business Phone # of Applicant/Licensee: _____

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.* if partnership or equal shareholders

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: _____

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

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 the rest of the application pages, please complete **ONLY** those changes being requested.

1. FACILITY NAME: _____

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

Street: _____

City _____ Zip Code _____ County _____

*Facility Telephone Number (_____) _____ Fax Number (_____) _____

*must be installed and operable prior to licensing-no cell phones.

3. FACILITY CORRESPONDENCE MAILING ADDRESS:

Name: _____

Street: _____

City _____ Zip Code _____ County _____

Email Address: _____

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

5. NAME OF CONTACT PERSON :(First, MI, Last) _____

Title: _____

Telephone Number (_____) _____ Cell # (_____) _____ Fax Number (_____) _____

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: _____

Name of Contact Person: _____

Address: _____

Telephone Number (_____) _____ Fax Number (_____) _____

7. LOCAL MANAGEMENT ENTITY/ MANAGED CARE ORGANIZATION (LME/MCO):

List name(s) of LME/MCOs with which the facility has a contract:

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

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: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (_____) _____ Fax (_____) _____

(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: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (_____) _____ Fax (_____) _____

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: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone #: (_____) _____ Fax (_____) _____

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

Facility Name: _____ MHL #: _____

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

Non-Profit Companies

If no individual holds an interest of 5% or more please sign the statement below, thereby indicating this is a non-profit group.

There are **no owners, partners, affiliates of shareholders who hold an interest of 5% or more** of the entity applying for license:

Signature Title Date

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) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # of Shareholder: (_____) _____ Fax (_____) _____

Percentage interest in this facility: _____ Title: _____

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

10. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute 122C-23 also requires information about “affiliates” of the applicant entity.

(a) Is the facility controlled by an organization that operates any other licensed mental health facility?

Yes _____ No _____

(b) Does the applicant control any other licensed mental health facilities? Yes ____ No ____

(c) Does the applicant control other organizations that control Mental Health facilities? Yes ____ No ____

(d) If the answer to (a) or (c) above is “Yes” list the name of the other organization(s)

Organization Name: _____	Federal Tax ID Number: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Organization Phone #: (_____) _____	Fax (_____) _____
Senior Officer or CEO: _____	
Chairman of the Board: _____	

Organization Name: _____	Federal Tax ID Number: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Organization Phone #: (_____) _____	Fax (_____) _____
Senior Officer of CEO: _____	
Chairman of the Board: _____	

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

11. SERVICE CATEGORIES:

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

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

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				
.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				

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

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.				
5600A Group homes for <u>adults</u> whose primary diagnosis is mental illness (Max. of 6 clients)				
5600B Group homes for <u>minors</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600C Group homes for <u>adults</u> whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600D Group homes for <u>minors</u> with substance abuse problems				
.5600E Half-way houses for <u>adults</u> with substance abuse problems				
.5600F Alternative family living – providing service in own private residence (Max. 3 clients)				

12. DO YOU HAVE A CERTIFICATE OF NEED? Yes No
 Required for the following service categories: .2100, .3400, & .5600 (only when ICF/IID facility)
 If yes, CON Number _____ Date _____

13. 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 DHRS's Acute & Home Care section's CLIA branch for information on obtaining CLIA waiver: <http://www.ncdhhs.gov/dhsr/ahc/cli/index.html>

14. 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.

15. 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 these non-ambulatory? Yes No

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

CONSTRUCTION: PHYSICAL PLANT

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

Zoning Department Official

Department Name: _____	Official's Name: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Building Official

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Fire Marshall

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

Local Sanitation

Department Name: _____	Inspector Name*: _____	
Address: _____		
City: _____	State: _____	Zip Code: _____
County: _____	Phone :(_____)	

*Provide Inspector's name if Inspection completed and copy attached.

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? _____

(*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
Division of Health Service Regulation
Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

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
.2400	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
.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
.3500	Outpatient Facilities for Individuals with Substance Abuse Disorders	No	Group B- Business Occupancy	a
.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

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

.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 14 (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 14 (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 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.