APPLICATION FOR CREDENTIAL FOR A QUALIFIED RESIDENTIAL TREATMENT PROGRAM

☐ Initial Application ☐ Relicensure ☐ Amendment

Date of Application: _____

Pursuant to 65C-14 Florida Administrative Rule, application is hereby made to:

_____ Operate a credentialed Qualified Residential Treatment Program, that provides treatment, care, and supervision for children or youth serious emotional or behavioral disorders or disturbances.

☐ 24-hour shift staff, or ☐ House Parent

☐ Agency is owned or run by the County, State, or Government with ☐ more than 25 beds.

☐ Agency is located on a campus setting.

Agency Name: _____ **Also Known As: _____**

Main Office Address: _____

Facility Address: _____

Applicant's (Licensee) Name: _____

Not for Profit Agency (Y/N): _____ **Medicaid Provider (Y/N): _____**

Accreditation Type: _____ **Federal Tax ID Number: _____**

Date of Accreditation renewal: _____ **Capacity Requested: _____**

Contact Information	Name	Phone Number	Email Address
Licensee:			
Primary Contact:			
Program Director:			

Have you ever served as a board member, executive director, or other office of an agency that failed to secure a license or where the license was revoked? ☐ No ☐ Yes, _____

If yes, please list your role, agency name and State.

Please list additional facilities that are overseen by the licensee:

If space is required for additional locations, please provide information on an additional page of this application.

Name of Facility *(If different from above)*	**Address**	**City, State, Zip Code**	**County**	**Subtype**
1.				
2.				
3.				
4.				

5.				
6.				
7.				
8.				

I understand the following responsibilities, as the applicant for a credential issued by the Department, includes but is not limited to the following:

- Ensure compliance with Florida Statutes 409.175 and Florida Administrative Code 65C-14 applicable to the child-caring agency credential standards identified for the location.
- Ensure timely response and action to resolve all identified licensing deficiencies or corrective actions involving the primary or satellite offices listed on this application.

I further understand that failure to oversee and comply with these responsibilities may impact the status of this child-caring agency credential license.

_____ _____

Applicant (Licensee) Signature Date

_____ _____

Applicant (Licensee) Signature Date