SUBSTANCE USE DISORDER TREATMENT SERVICES
FACILITY STATE APPROVAL APPLICATION

Applicant Information:

Applicant Name: _____

Mailing Address: _____

Physical Address: _____

City: _____State/Zip: _____

Applicant Telephone Number: _____FAX: _____

Applicant E-mail/Web Page Address: _____

Applicant Administrator: _____

Days of Operation_____ Hours Operation_____

Indicate type of service to be State Approved (mark all that apply)

☐ 3.7 Medically Monitored Intensive Inpatient Services
☐ 3.5 Clinically Managed High-Intensity Residential Services
☐ 3.3 Clinically Managed Population – Specific High-Intensity Residential Services
☐ 3.1 Clinically Managed Low-Intensity Residential Services
☐ 2.5 Partial Hospitalization Services
☐ 2.1 Intensive Outpatient Services
☐ 1.0 Outpatient Services
☐ 0.5 Early Intervention
☐ DUI Educational Services
☐ MIP Educational Services

Proposed Service Area

Provide a list of each county where the Applicant proposes to provide chemical dependency treatment services under this State Approval application. (listing telehealth to all counties will not be accepted)

County: _____

County: _____

County: _____

County: _____

Please include the following with the application:

- List of all Applicant site addresses and phone numbers
- Copy of Health Care Facility License
- Documentation demonstrating local need *for each county* in application (see application supplement)
- Projected services form *for each county* in application (see applicationsupplement)

Application materials can be sent to: bhddapprovalapps@mt.gov.

I certify that all information I have submitted to DPHHS is true and correct. This Application for a Substance Use Disorder Treatment Services State Approval is hereby submitted under the provision of Section 53-24-101 through 53-24-306.

I understand the application and possible issuance of a Certificate of State Approval for Substance Use Disorder Treatment Services does not entitle any facility listed in this application to a contract for services or other funding available for chemical dependency treatment services.

Signature: _____Date: _____

Printed Name: _____

Title: _____

Address: _____City: _____State/Zip: _____