DEPARTALENT OF STATU						Submiss	sion Date (Month/Day/Year)
CHIDA MARY		Applica	tion Fo	or			au Application
OF ···	L	icensing	to Pro	vide			ew Application Renewal
CHILL CHILL	S	UBSTAN	CE AB	USE			Relocation
AND V	TRI			VICES		Anticipa Relocat	ated ion Date:
MyFLFamilies.com							hange in Organization
I. SERVICE PROVIDER INFORMATION           1. Service Provider Legal Name (if multiple locations, enter CORPORATE HEADQUARTERS name)         2. Federal ID #         3. National Provider ID (NPI)							
	<b>p</b> .ee.,						
4. Name of the Service Provider's Owner 5. Corporate Website Address				lress			
6. Corporate / Owner's Mailing Addres	SS						
		1				1	
6a. City		6b. State		6c. Zip Cod	e	6d. Cou	nty
7. Circuit/Region	8. Te	lephone (Area Co	de & Numbe	r)	9. Fax T	elephone	(Area Code and Number)
10. Physical Address (If different from	mailing address)						
To. Physical Address (if different from	maining address)						
10a. City		10b. State		10c. Zip Co	de	10d. Co	unty
10e. Provider Point of Contact E	mail Addrage:						
11. Is the applicant accredited b		rganization apr	proved by th	ne Departm	nent? If	so, pleas	se include the
accrediting organization's in						, p	
Name of Accrediting Orga							
Three-Year			Accreditatio	-			
For renewals, please submit accreditation status.	the most rece	nt accreditatio	on survey i	report with	this ap	plicatio	n including changes in
12. Type of Legal Entity: Check	the applicable	box(es) below					
Profit; check type of "For	Profit" below:			Non-Profit			
Please check applicable	boxes:			Foreign Li	mited Lia	ability Pa	rtnership
Private Practitione	er						
Faith-Based Provi	ider						
Community Subst	ance Abuse Co	alition					
13. Are you currently contracted	with the Depa	rtment of	14. Do yo	u accept th	e followi	ing recip	ients?
Children and Families?			Media	caid 🗌 I	ndigent I	Persons	Pregnant Women
		f Elevide O	10 If	- 41			**NI Du-fit
15. Is the agency incorporated v	vith the State o	f Florida?					**Non-Profit of IRS Form 990.
				Yes	No		
				_			

If incorporated, submit the names of the owner, board members, officers and shareholders. (*Must be Background screened per Section 397.4073, F.S., and Chapter 453, F.S.)			
17. Name of Owner*			
18a. Name of the Chief Executive Officer*	18b. Chief Executive Officer's Email Address		
19. Name of the Chief Financial Officer*	·		
20. Name of the Staff Training Coordinator			
21. Name and professional license number of Medical Director			
intensive inpatient treatment, residential treatment, day or addiction). Submit proof of a valid medical license accomp	night treatment, and medication-assisted treatment for opioid		
documentation:	surfice by, molecular bat not infined to, the following		
a. A copy of photo identification matching that of the p	-		
	s (1) employed or contracted by the provider as a medical she is acting (addictions receiving facility, detoxification,		
intensive inpatient treatment, residential treatment,	or methadone medication-assisted treatment); and (2)		
knowledgeable of the limit to acting as medical direct	ctor for no more than 10 facilities within a 200-mile radius.		
Name of Medical Director*:	License Number:		

**EXEMPTIONS:** Pursuant to Chapter 397.4014, F.S., Inmate Substance Abuse Programs are exempt from providing specific documentation in the application process. "Inmate Substance Abuse Services" means any service component as defined in S. 397.311 provided directly by the Department of Corrections and licensed and regulated by the Department of Children and Families pursuant to Chapter 397.752 – 397.754, F.S. or provided through contractual arrangements with a service provider licensed pursuant to Chapter 397, Part VIII, or any self-help program or volunteer support group operating for inmates.

An application without the applicable licensure fee as required under Section 397.407, Florida Statutes and Section 65D-30.0035, Florida Administrative Code, will be returned to the applicant. An application for renewal of a regular license must be submitted to the Department at least 90 calendar days before the license expires. A late fee of \$100 per license component shall be assessed for the late filing of an application as required under Section 397.407(2) Florida Statutes.

Please make check payable to the Florida Department of Children and Families.

Signature of the Chief Execut	tive Officer (Original signature	only)	Date	e (month, day, year)
Renewal Attestation				
attest that no changes were	made to the following	documents (pl	ease check all that app	ly):
Policy and Procedure	Manual			
Organizational Chart	Severation (Musthe version	aitted av am / E v a	)	
0	Screening (Must be resubn nt Check (Must be resubn		,	
	ed Professional(s) (Must re			
□ Service Fee/Service (	( ) (	Soushing over y	o youro)	
PLADS in order to be proces	ssed with the renewal a	application. All	other required docu	imentation for renewa
PLADS in order to be proces nust be submitted on an ann	ssed with the renewal a	application. All	other required docu	imentation for renewa
PLADS in order to be proces nust be submitted on an ann	ssed with the renewal a	application. All	other required docu	imentation for renewa
PLADS in order to be proces nust be submitted on an ann	ssed with the renewal a	application. All	other required docu	imentation for renewa
PLADS in order to be proces nust be submitted on an ann o process your application.	ssed with the renewal a ual basis. For new appl	application. All	other required docu	Imentation for renewant to be submitted in orde
PLADS in order to be proces nust be submitted on an ann o process your application.	er (Original signature only)	application. All licants, all requ	other required docu ired documents mus	Imentation for renewant to be submitted in orde
PLADS in order to be process nust be submitted on an ann o process your application. Signature of the Chief Executive Office II. PROGRAM COMPONE	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION -	application. All licants, all requ – Location 1	other required docu ired documents mus	imentation for renewa t be submitted in orde
PLADS in order to be process nust be submitted on an ann o process your application. Signature of the Chief Executive Office II. PROGRAM COMPONE	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION -	application. All licants, all requ – Location 1	other required docu ired documents mus	Imentation for renewant to be submitted in orde
PLADS in order to be process nust be submitted on an ann o process your application. Signature of the Chief Executive Office II. PROGRAM COMPONE Name of Program (e.g., Adult Outpatie	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION -	application. All licants, all requ – Location 1 I Treatment, Outread	other required docu ired documents mus Date (month, of th Prevention, etc.) 2. Tele	t be submitted in orde
PLADS in order to be process nust be submitted on an ann o process your application. Signature of the Chief Executive Office II. PROGRAM COMPONE Name of Program (e.g., Adult Outpatie	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION -	application. All licants, all requ – Location 1 I Treatment, Outread	other required docu ired documents mus	t be submitted in orde
PLADS in order to be process nust be submitted on an ann o process your application. Signature of the Chief Executive Office II. PROGRAM COMPONE Name of Program (e.g., Adult Outpatie Street Address	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION -	application. All licants, all requ – Location 1 I Treatment, Outread	other required docu ired documents mus Date (month, of th Prevention, etc.) 2. Tele	t be submitted in orde
LADS in order to be process nust be submitted on an ann process your application. ignature of the Chief Executive Office I. PROGRAM COMPONE Name of Program (e.g., Adult Outpatie Street Address	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION - ent Treatment, Youth Residentia 6. State	application. All licants, all requinants, all requinants, all requinants, all requinants, and the second se	other required docuired documents mus	t be submitted in orde
City	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION - ent Treatment, Youth Residentia	application. All licants, all requination of the second state of t	other required docuired documents mus	day, year) ephone (Area Code & Number , etc.
Note: If changes have occurr PLADS in order to be process must be submitted on an ann to process your application. Bignature of the Chief Executive Office II. PROGRAM COMPONE Name of Program (e.g., Adult Outpatie Street Address City D. Current License Number 2. Name of Program Director*	essed with the renewal a ual basis. For new appl er (Original signature only) ENT INFORMATION - ent Treatment, Youth Residentia 6. State	application. All licants, all requination of the second state of t	other required docu         ired documents mus	day, year) ephone (Area Code & Number , etc.

14a. Addictions Receiving Facility:         Please check if you are seeking designation and a license         Addictions Receiving Facility         Juvenile Addictions Receiving Facility         Juvenile Addictions Receiving Facility         Integrated         Licensed Bed Capacity:         Inpatient Detoxification         Licensed Bed Capacity:         Inpatient Methadone Detoxification         Licensed Bed Capacity:	<ul> <li>14d. <i>Residential Programs:</i> <ul> <li>Level 1; Total Bed Capacity:</li> <li>Level 2; Total Bed Capacity:</li> <li>Level 3; Total Bed Capacity:</li> <li>Level 4; Total Bed Capacity:</li> <li>Level 4; Total Bed Capacity:</li> </ul> </li> <li>14e. <i>Day or Night Treatment Programs with Community Housing:</i> <ul> <li>Day or Night Treatment Programs with Community Housing</li> <li>Location of Housing:</li> <li>Total Bed Capacity:</li> </ul> </li> </ul>	<ul> <li>14i. Aftercare Programs:</li> <li>Aftercare</li> <li>14j. Intervention Programs:</li> <li>Case Management</li> <li>General Intervention</li> <li>Employee Assistance Program</li> <li>Treatment Alternatives for Safer Communities (TASC)</li> <li>14k. Prevention Programs:</li> <li>Universal Direct</li> <li>Selective</li> <li>Indicated</li> </ul>
<ul> <li>Outpatient Detoxification</li> <li>Outpatient Methadone Detoxification</li> <li>14c. Intensive Inpatient Treatment Programs:</li> <li>Intensive Inpatient Treatment Licensed Bed Capacity:</li> </ul>	<ul> <li>14f. Day or Night Treatment Programs:</li> <li>Day or Night Treatment</li> <li>14g. Intensive Outpatient Programs:</li> <li>Intensive Outpatient Treatment</li> <li>14h. Outpatient Programs:</li> <li>Outpatient Treatment</li> </ul>	<ul> <li>14I. Medication-Assisted Treatment for Opioid Addiction Programs:</li> <li>Medication and Methadone Maintenance Treatment</li> <li>Medication Unit Maximum Capacity:</li> </ul>

15. Hours during v	which the proo	gram is open:	16. Submit with this application evidence of compliance for applicable
Monday:	to	Closed	areas below (including applicable expiration date): <u>Expiration Date</u>
Tuesday:	to	Closed	Fire and Safety: Yes No
Wednesday:	to	Closed	Health Standards: Facility Inspection: Yes No N/A
Thursday:	to	Closed	Food Services: Yes No N/A
Friday:	to	Closed	Zoning Compliance: Yes No
		_	Property Insurance: Yes No
Saturday:	to	Closed	Professional Liability Yes No
Sunday:	to		Recovery Residence Referral Log: Yes No N/A
			Affidavit of Good Moral Character: 🗌 Yes 🔲 No
			Policy & Procedure Manual: 🗌 Yes 🛛 No N/A
			Current Organizational Chart: Yes No
			Level 2 Background Screening: Yes INo
			Local Law Enforcement Check: Yes No
			Verification of Qualified Professional(s): Yes No
			Treatment Resource Attestation: Yes No
			Service Fee Schedule: 🗌 Yes 🔲 No
			Policies regarding an Individual's financial responsibility:
			Yes No
			Provide proof of the availability and provision of meals for the following:
			Addictions receiving facilities:  Yes No Day and Night Treatment, If applicable: Yes No
			Residential Treatment:
			Day or night treatment with community housing: Yes No
			<b>Note:</b> Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.
II. PROGRAM	И СОМРО	NENT INFORMATION -	- Location 1 (Continued)
		nent (i.e., programs which use nents with this application.	methadone or other medications for treating opioid addiction). Submit
· · ·	thadone Aut	••	
Board of	Pharmacy –	submit a copy of the pharmacy	/ permit
Verificati	on of the serv	vices of a consultant pharmacis	st
Not Appl	icable		
			n and verification of Substance Abuse and Mental Health Services ed prior to the issuance of a regular license.
18. Have all staff a	and volunteer	s who have direct contact with	clients under the 19. What is the maximum number of clients that can
		ith developmental disabilities b e with section 397.4073(1)(a),	

Yes No Not Applicat	ble
20. Target Population:	
White (Non-Hispanic) American Ind	lian 🗌 Hispanic 🗌 Black (Non-Hispanic)
Other (please describe):	
21. List any special population group targeted for se justice clients, etc.)	ervices (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal
Children	HIV/AIDS
Women	Hearing Impaired
Adolescents	Visually Impaired
Homeless	Older Adults
Criminal Justice-Involved Adults	
Juvenile Justice-Involved Youth	Intravenous Drug Users
Pregnant and Post-Partum Women	Other (please describe other group):
Pregnant and Post-Partum Adolescents	
	tioners with which you have written referral agreements, contracts, or subcontracts,
and check the type of business relationship:	Agreement Contract Subcontract Other (specify):
a.	
b.	Agreement Contract Subcontract Other (specify):
С.	Agreement Contract Subcontract Other (specify):
d.	Agreement Contract Subcontract Other (specify):
е.	Agreement Contract Subcontract Other (specify):
23 List the sources of revenue you receive by nam	e and check the type of funds, e.g., state funds, federal funds, fees, etc:
a.	State Federal Fees Private Other (specify):
b.	State Federal Fees Private Other (specify):
	State Federal Fees Private Other (specify):
С.	State Federal Fees Private Other (specify):
d.	
e.	State Federal Fees Private Other (specify):

## II. PROGRAM COMPONENT INFORMATION – Location 2

1. Name of Program (e.g., Adult Outpatient Treatm	ent, Youth Residential T	reatment, Outreac	h Prevention, etc.) 2. Telephone (Area Code & Number)
3. Street Address		4. Building Num	ber, Room Number, Suite, etc.
5. City 10. Current License Number	6. State Florida	7. Zip Code	8. Circuit/Region 9. County ense Expiration Date (MM/DD/YY)
<ul> <li>12. Name of Program Director*</li> <li>14. Type of Service Component (please chemical descent)</li> </ul>	eck all that apply fo	13. Name of Cli	nical Director*
14a. Addictions Receiving Facility:       1         Please check if you are seeking designation and a license       1         Addictions Receiving Facility       1         Juvenile Addictions Receiving Facility       1         Juvenile Addictions Receiving Facility       1         Integrated       1         Licensed Bed Capacity:       1         14b. Detoxification Programs:       1         Inpatient Detoxification       1         Licensed Bed Capacity:       1         Outpatient Methadone       1         Outpatient Detoxification       1         Inpatient Detoxification       1         Inpatient Methadone       1         Detoxification       1         Inpatient Methadone       1         Outpatient Methadone       1         Inpatient Methadone       1         Inpatient Methadone       1         Inpatient Methadone       1         Intensive Inpatient Treatment       1	<ul> <li>4d. <i>Residential Pro</i></li> <li>Level 1; Total 1</li> <li>Level 2; Total 1</li> <li>Level 3; Total 1</li> <li>Level 3; Total 1</li> <li>Level 4; Total 1</li> <li>Licensed Bed C</li> <li>4e. <i>Day or Night Tr</i></li> <li>with Communit</li> <li>Day or Night Tr</li> <li>with Communit</li> <li>Location of Hou</li> <li>Total Bed Capa</li> <li>4f. <i>Day or Night Tre</i></li> <li>Day or Night Tre</li> <li>Day or Night Tre</li> <li>Day or Night Tre</li> </ul>	grams: Bed Capacity: Bed Capacity: Bed Capacity: Bed Capacity: Capacity: Capacity: Capacity: eatment Progra ity Housing using: freatment Programs atient Programs patient Treatment	14i. Aftercare Programs:         Aftercare         14j. Intervention Programs:         Case Management         General Intervention         Employee Assistance Program         Treatment Alternatives for Safer Communities (TASC)         ams         14k. Prevention Programs:         Universal Direct         Selective         Indicated         ms:         14l. Medication-Assisted Treatment for Opioid Addiction Programs:

15. Hours during w	hich the pro	gram is open:	16. Submit with this application evidence of compliance for applicable	
Monday:	to	Closed	areas below (including the expiration date): Expiration Date	
Tuesday:	to	Closed	Fire and Safety: Yes No	
			Health Standards:	
Wednesday:	to	Closed	Facility Inspection: Yes No N/A	
Thursday:	to	Closed	Food Services: Yes No N/A	
Friday:	to	Closed	Zoning Compliance: Yes No	
Saturday:	to	Closed	Property Insurance: Yes No	
Sunday:	to	Closed	Professional Liability Yes No Insurance	
			Recovery Residence Referral Log: Yes No N/A	
			Affidavit of Good Moral Character: 🗌 Yes 📃 No	
			Policy & Procedure Manual: Yes No N/A	
			Current Organizational Chart: Yes No	
			Level 2 Background Screening: Yes No	
			Local Law Enforcement Check: Yes No	
			Verification of Qualified Professional(s): Yes No	
			Service Fee Schedule: 🗌 Yes 🗌 No	
			Treatment Resource Attestation: 🗌 Yes 🛛 No	
			Policies regarding an Individual's financial responsibility:	
			🗌 Yes 🔲 No	
			Provide proof of the availability and provision of meals for the	
			following: Addictions receiving facilities:	
			Residential Treatment:   Yes   No Day and Night Treatment, If applicable:  Yes  No	
			Day or night treatment with community housing: Yes D No	
			<b>Note:</b> Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Professional Liability Insurance and Recovery Residence Log requirements.	
			- Location 2 (Continued)	
		nent (i.e., programs which use <b>nents with this application.</b>	methadone or other medications for treating opioid addiction). Submit	
State Me	State Methadone Authority			
Board of	Board of Pharmacy – submit a copy of the pharmacy permit			
Verification of the services of a consultant pharmacist			st	
Not Appli	icable			
			n and verification of Substance Abuse and Mental Health Services red prior to the issuance of a regular license.	

18. Have all staff and volunteers who have direct contact with or the age of 18 years or adults with developmental disabilities fingerprinted and screened in accordance with section 397. Florida Statutes?	s been be served in this component on a given day?
Yes No Not Applicable	
20. Target Population:	
White (Non-Hispanic)	lispanic 🔄 Black (Non-Hispanic)
Other (please describe):	
21. List any special population group targeted for services (e.g. justice clients, etc.)	, hearing impaired, pregnant alcoholics or addicts, youth, criminal
Children	HIV/AIDS
Women	Hearing Impaired
Adolescents	Visually Impaired
Homeless	Older Adults
Criminal Justice-Involved Adults	Co-occurring
	Intravenous Drug Users
Pregnant and Post-Partum Women	Other (please describe other group):
Pregnant and Post-Partum Adolescents	
22. List the complete names of agencies or practitioners with v subcontracts, and check the type of business relationship:	which you have written referral agreements, contracts, or
a. Agreem	ent Contract Subcontract Other (specify):
b. Agreem	ent Contract Subcontract Other (specify):
c. Agreem	ent Contract Subcontract Other (specify):
d. Agreem	ent Contract Subcontract Other (specify):
e. Agreem	ent Contract Subcontract Other (specify):
23. List the sources of revenue you receive by name and chec	
a. State	Federal Fees Private Other (specify):
b. State	Federal Fees Private Other (specify):
c. State	Federal Fees Private Other (specify):
d. State	Federal Fees Private Other (specify):
e. State	Federal Fees Private Other (specify):
II. PROGRAM COMPONENT INFORMATION -	Location 3
1. Name of Program (e.g., Adult Outpatient Treatment, Youth Residential	Treatment, Outreach Prevention, etc.) 2. Telephone (Area Code & Number)
3. Street Address	4. Building Number, Room Number, Suite, etc.
5. City 6. State	7. Zip Code     8. Circuit/Region     9. County
10. Current License Number	11. Current License Expiration Date (MM/DD/YY)
12. Name of Program Director*	13. Name of Clinical Director*
14. Type of Service Component (please check all that apply f	or this location):

14a. Addictions Receiving Facility:	14d. Residential Programs:	14i. Aftercare Programs:
Please check if you are seeking	Level 1; Total Bed Capacity:	Aftercare
designation and a license	Level 2; Total Bed Capacity:	14j. Intervention Programs:
Addictions Receiving Facility	Level 3; Total Bed Capacity:	Case Management
Juvenile Addictions Receiving	Level 4; Total Bed Capacity:	General Intervention
Integrated	Licensed Bed Capacity:	Employee Assistance Program
Licensed Bed Capacity:	14e. Day or Night Treatment Programs	Treatment Alternatives for Safer
14b. Detoxification Programs:	with Community Housing:	Communities (TASC)
Inpatient Detoxification	with Community Housing	14k. Prevention Programs:
Licensed Bed Capacity:	Location of Housing:	Universal Direct
Inpatient Methadone	Total Bed Capacity:	Selective
Detoxification Licensed Bed Capacity:		Indicated
	14f. Day or Night Treatment Programs:	14. Medication-Assisted Treatment for
Outpatient Detoxification	Day or Night Treatment	Opioid Addiction Programs:
Outpatient Methadone Detoxification	14g. Intensive Outpatient Programs:	Medication and Methadone Maintenance Treatment
	Intensive Outpatient Treatment	Medication Unit
14c. Intensive Inpatient Treatment Programs:	14h. Outpatient Programs:	Maximum Capacity:
Intensive Inpatient Treatment	Outpatient Treatment	
Licensed Bed Capacity:		

15. Hours during w	hich the pro	gram is open:	16. Submit with this application evidence of compliance for applicable
Monday:	to	Closed	areas below (including the expiration date): Expiration Date
Tuesday:	to	Closed	Fire and Safety: Yes No
Wednesday:	to	Closed	Health Standards: Facility Inspection: Yes No N/A
Thursday:	to	Closed	Food Services:
Friday:	to	Closed	Zoning Compliance: Yes No
Saturday:	to	Closed	Property Insurance: Yes No
Sunday:	to	Closed	Professional Liability Yes No Insurance
			Recovery Residence Referral Log: Yes No N/A
			Affidavit of Good Moral Character: 🗌 Yes 📃 No
			Policy & Procedure Manual: Yes No N/A
			Current Organizational Chart: Yes No
			Level 2 Background Screening: Yes No
			Local Law Enforcement Check: Yes No
			Verification of Qualified Professional(s): Yes No
			Treatment Resource Attestation: 🗌 Yes 🔲 No
			Service Fee Schedule:
			Yes No
			Provide proof of the availability and provision of meals for the following: Addictions receiving facilities: Yes No
			Day and Night Treatment, If applicable: Yes No
			Residential Treatment: 🗌 Yes 🔲 No Day and Night Treatment, If applicable: 🗌 Yes 🗌 No
			Day or night treatment with community housing: Yes No
			Note: Inmate Substance Abuse Programs that are operated by or under contract with the Department of Corrections, Department of Juvenile Justice or the Department of Management Services are exempt from the Department in built in the University and the Department of Services and Services are set to be a service service and the Services are set to be a service service service service services are set to be a service service service service service services are set to be a service s
II. PROGRAM		NENT INFORMATION -	Professional Liability Insurance and Recovery Residence Log requirements. – Location 3 (Continued)
17. Medication-Ass	sisted Treatn		methadone or other medications for treating opioid addiction). Submit
· · ·	thadone Aut		
Board of	Pharmacy –	submit a copy of the pharmac	y permit
	Verification of the services of a consultant pharmacist		
Not Appli			
			verification of Substance Abuse and Mental Health Services red prior to the issuance of a regular license.

18. Have all staff and volunteers who have direct contact with clients under the age of 18 years or adults with developmental disabilities been fingerprinted and screened in accordance with section 397.4073(1)(a), Florida Statutes?	19. What is the maximum number of clients that can be served in this component on a given day?	
Yes No Not Applicable		
20. Target Population:		
🗌 White (Non-Hispanic) 📃 American Indian 🗌 Hispanic 🗌 B	Black (Non-Hispanic)	
Other (please describe):		
21. List any special population group targeted for services (e.g., hearing impaire justice clients, etc.)	ed, pregnant alcoholics or addicts, youth, criminal	
Children HIV/AI	DS	
Women	g Impaired	
Adolescents	y Impaired	
Homeless Older A	Adults	
Criminal Justice-Involved Adults	urring	
Juvenile Justice-Involved Youth	nous Drug Users	
Pregnant and Post-Partum Women Other (please describe other group):		
Pregnant and Post-Partum Adolescents		
22. List the complete names of agencies and practitioners with which you have subcontracts, and check the type of business relationship:	written referral agreements, contracts, or	
a. Agreement Contra	ct Subcontract Other (specify):	
b. Agreement Contra	ct Subcontract Other (specify):	
c. Agreement Contra	ct Subcontract Other (specify):	
d. Agreement Contra	ct Subcontract Other (specify):	
23. List the sources of revenue you receive by name and check the type of func		
a. State Federal	Fees Private Other (specify):	
b. Enderal Enderal	Fees Private Other (specify):	
c. Enderal Enderal	Fees Private Other (specify):	
dStateFederal	Fees Private Other (specify):	
e. State Federal	Fees Private Other (specify):	