DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES • • • • • • • • STATE OF FLORIDA
Emmett S. Roberts, Secretary
Reubin O'D Askew, Governor
OFFICE OF THE SECRETARY
DRUG ABUSE PROGRAM • 3000 Biscayne Boulevard, Suite 206 A Miami, Florida 33137
Frank D. Nelson, Director
PHONE: (305) 576-0510

Dear Applicant:

Enclosed please find the Drug Abuse Treatment and Education (DATE) Center application and its instructions for 1973 licensure. I have also enclosed the procedure used for licensing in Region XI.

This year it will be necessary to make application for each facility not connected or on the same property with another facility. The license is valid only for the particular facility and Director designated in the application. If either changes during the period the license is valid, calendar year 1973, there must be a new application filed with my office for review.

An application must be made for each service available, i.e. residential, non-residential, education, hot-line, methadone maintenance, ect., per each facility. One license will be issued per facility, possibly showing more than one service, but multiple licenses will be issued for programs having more than one facility, again, if they are not connected or on the same property.

A very necessary section of the application is written statements approving the health, fire, safety and zoning of each facility by the proper authorities. These written approvals must accompany the application. Also, the Source and Application Funds Statement and the Balance Sheet must be completed by the Director and notarized prior to the submission of the application. These are immediate requirements.

Applications must be completed immediately and returned to my office so I may review your application and accept or request additional information. An on-site visit will then be performed prior to submitting the application to the Drug Abuse Task Force for review.

Thank you ahead of time for your cooperation. If you have any questions please call the above number.

Sincerely,

Charles A. Lincoln
Regional Coordinator

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Procedure for programs seeking Drug Abuse Treatment and Education (DATE) Center License for State of Florida, Department of Health and Rehabilitative Services, Drug Abuse Program, Region XI (Dade and Monroe Counties).

1. APPLICATION FOR LICENSE IS COMPLETED BY APPLICANT AGENCY.

   One application per facility. Assistance will be given to the agency by the Regional Coordinator and Youth Coordinator if so requested.

2. APPLICATION IS REVIEWED BY REGIONAL COORDINATOR.

   If all required information is not included in the application, it is returned for finalizing. When the application is completed the procedure continues.

3. AN ON-SITE VISIT IS PERFORMED BY THE REGIONAL COORDINATOR WITH THE AIDE OF THE YOUTH COORDINATOR.

   During the visit an evaluation is made as to the agency's ability to meet the State requirements as well as approved local guidelines.

4. APPEARANCE OF THE AGENCY'S EXECUTIVE DIRECTOR APPLICANT BEFORE THE HEALTH PLANNING COUNCIL, DRUG ABUSE TASK FORCE FOR APPLICATION REVIEW.

   A copy of the application and a checklist of the required information is supplied to the members of the Task Force at the most immediate meeting after receipt of the application. The Executive Director must be present and should be prepared to answer pertinent questions relating to his program. A decision is based on a simple majority of the members present of the Drug Abuse Task Force. Alternative decisions may be:

   A. Approve application for a calendar year license.

   B. Approve application for an interim, three month license. This will include stated deficiencies which must be satisfied during the three month period.

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C. Table application until the next meeting in order to study further.

D. Not approve the agency's request for a license.

5. DRUG ABUSE TASK FORCE RECOMMENDATION IS FORWARDED TO THE HEALTH PLANNING COUNCIL BOARD OF DIRECTORS.

The Drug Abuse Task Force recommendation must be acted upon. It may be approved, not approved or returned to the Task Force for further study.

6. THE DECISION OF THE HEALTH PLANNING COUNCIL ALONG WITH THE REGIONAL COORDINATOR'S RECOMMENDATION IS FORWARDED TO THE STATE OFFICE OF DRUG ABUSE.

If there is a difference between the recommendations of the Drug Abuse Task Force and the HPC, Board of Directors relative to licensing both recommendations and pertinent materials will be forwarded to the State for final determination.

7. FINAL DECISION ON THE LICENSE REQUEST IS DETERMINED BY THE STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, OFFICE OF DRUG ABUSE, TALLAHASSEE, FLORIDA.

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Instructions for filling out
License Application Form

Complete separate application forms for each major component of the program, e.g., a residential treatment center with a speakers bureau would apply for license as a residential treatment center only. However, a program with a methadone maintenance program and a residential treatment center should apply for two licenses.

NOTE: Numbers below correspond to numbers on application form.

1. List name of program as it is chartered with Secretary of State.

2. Include Zip Code and Area Code.

3. Identify chief administrative authority for overall program. Also, identify person responsible for program component for which this license is sought.

4. This refers to the major directing or advisory body to the program.

7. Each program should be chartered as a private non-profit corporation or as a private profit corporation with the Secretary of State. Any exceptions should be explained.

8. Funding sources include all federal, state, and units of local government as well as private donations.

9. This refers to total beds available in a Residential Treatment Center or number of clients the facility can accommodate in a day care center, rap house, detoxification or other in-patient or out-patient facility. Indicate not applicable by NA for Hot Lines, Educational Program, Coordinating or Administrative Programs.

10. Is any fee charged and, if so, is it based on client's ability to pay?

11. List formal contractual or other written agreements, not including letters of endorsement or support.

12. Describe primary group for which program actually provides service in terms of average age and whether it is particularly oriented toward one ethnic or social group. If service is restricted to males or females only, please indicate.

13. Experimenters - Those persons, usually young, who are not addicted, not heavily involved, but for whom intervention services are appropriate to prevent further involvement.

    Multiple drug users - Age is not necessarily significant; not addicted, whose drug use is frequent and includes a variety of different drugs.

    Multiple drug abuser - Age is not necessarily significant; use of many drugs is interfering with activities such as school, employment, family relations; physical and/or psychological problems may exist.

[illegible]. Addicts - Withdrawal symptoms occur when the drug is absent; physical, and psychological dependency exists; the dependency greatly interferes with usual activities.

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14. Objectives should be described in measurable behavioral terms including immediate and long range goals. List the services offered as specifically as possible.

15. Programs must send in all official documents relevant to their particular facility.

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STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
DRUG ABUSE PROGRAM

APPLICATION FOR LICENSE TO OPERATE A DRUG ABUSE TREATMENT OR EDUCATION PROGRAM

DATE ____________________

1. Name of Program ____________________

2. Address ____________________ TELEPHONE ____________________
   ____

3. Names of Chief Administrator and the Program Director (attach resumes)

   ____

   ____

4. Names of all members of the executive board:

   ____

   ____

   ____

   ____

   ____

5. Type of program (check one)

   (a) ____Residential Treatment Center
   (b) ____Non-Residential Treatment Center
   (c) ____Methadone Maintenance
   (d) ____Detoxification
   (e) ____Transitional Facility
   (f) ____Rap House
   (g) ____Hot Line
   (h) ____Education
   (i) ____Outpatient
   (j) ____Free Clinics

   (k) ____Other (specify) ____________________

6. Is the program licensed by any other authority? ____Yes ____No

   Attach copy of license ____________________

7. Attach copy of charter from Secretary of State ____________________

8. Funding Sources

Funding Sources	Time Period Covered	Amount
______	______	______
______	______	______
______	______	______

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9. Maximum capacity____

10. Fee charged__________________ If yes, how determined?____________

____

11. List written referral agreements, affiliate agreements, contracts or sub-contracts with drug abuse programs and other agencies in your area. (Use reverse side for listing)

12. Describe target population, including average age and race or ethnic group.

____

____

____

13. In which <u>one</u> of the following categories would you place <u>most</u> of your clients?

experimenters ____
multiple drug users ____
multiple drug abusers ____
addicts ____

14. Describe your program in terms of its objectives and services offered.

____

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15. Attach copy of certification which shows compliance with regulations of health department, municipal zoning office, county zoning office or consolidated zoning office.

16. Briefly describe the building in which your program is housed in terms of structure, size and other descriptive data. (Use reverse side)

Applicant______________________

Name ______________________

Title ______________________

Signature______________________

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11. ____

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16. ____

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SOURCE AND APPLICATION OF FUNDS STATEMENT FOR THE YEAR ENDING __________, 19___

SOURCE:

Operation Revenue	$__________
Income From Trust Funds	__________
Income From Investments	__________
Local Government Aid	__________
State Government Aid	__________
Federal Government Aid	__________
Donations by Source	
1.	__________
2.	__________
3.	__________
TOTAL FUNDS RECEIVED	$__________

APPLICATION:

Expenditures

1. Salaries	$__________
2. Equipment Purchases	__________
3. Operating Expenses	__________
4. Debt Retirement	__________
5. Purchase of Investments	__________
6. Unexpended Funds (Balancing Figure)	__________
TOTAL FUNDS APPLIED	$__________

I hereby certify the above to be a true and accurate statement in all respects.

____
Notary Public

____
Program Director

Date ______________________________

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BALANCE SHEET FOR THE YEAR ENDING __________, 19___

ASSETS			LIABILITY AND FUND EQUITY (Current)	
Cash		$________	Accounts Payable	$________
Receivables	________		Notes Payable	________
(Less Uncollectable Receivables)	________	________	Long Term Debt	________
Trust Funds and Investments		________	Mortgage Notes	________
Equipment	________		Facility Bonds	________
(Less Accumulated Depreciation)	________	________	Equity (Fund Balance)	________
Facility	________			
(Less Accumulated Depreciation)	________	________		
Land		________		
TOTAL ASSETS		$________	TOTAL LIABILITY AND FUND EQUITY	$________

I hereby certify the above to be a true and accurate statement in all respects.

____
Notary Public

____
Program Director

Date ______________________________

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1. I.D. ______ 2. Age ______ 3. Race ______ 4. Sex ______ 5. Location ______

6. Date(s) admitted ______ 7. Date(s) terminated ______ 8. Time in program ______

9. Referral Source:
   - School ______
   - Parents ______
   - DYS ______
   - Court ______
   - Other drug program ______
   - Other (specify) ______

10. Previous Attempts at Help:
    - Drug program ______
    - Other type of help ______
    - No previous attempt ______

11. Number of arrests ______

12. Number Convictions ______

13. Drug involvement (indicate length of time)
    - Heroin only ______
    - Amphetamines only ______
    - Barbiturates only ______
    - Hallucinogens only ______
    - Marijuana only ______
    - Multiple drugs ______
    - Other (specify) ______

14. Attitude problem ______

15. Reason for termination:
    - Successful completion of program ______
    - Left without approval ______
    - Dismissed ______
    - Referred elsewhere ______
    - Institutionalized ______
    - Other (specify) ______

16. Terminated during:
    - 10 to 10 ______
    - Second phase ______
    - Other (specify) ______

17. If terminated as successfully completing program:
    - date of last contact ______
    - living at home ______
    - in school ______
    - working ______
    - on staff of Seed ______
    - involved with drugs ______
    - lost or no follow up information ______

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