Online Application for Licensure to Provide Substance Use Services

CF-MH Form 4024a, July 2019 [65D-30.0034, F.A.C.]

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
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SITE PROFILE

SITE INFORMATION

Site Name

Site ID:

Site Street:

Room/Suite:

City:

State:

Phone Number:

Zip Code:

County:

Region:

Circuit:

Type of Services at Site:

DCF ACTIONS AND STATUS

Visible only to DCF staff when site is active or inactive

Site Status:

Change Site Information:

DCF Actions:

Component Request became Probationary

Designation Request Approved

RECEIVING FACILITY DESIGNATIONS

Receiving Facility Designation Request:

As a Receiving Facility provider, you can request several types of designations for this site. Select the Request Designation button below and then fill in appropriate information to start the request process.

Designation Requested For:

Designation Type:

- ☐ Hospital
- ☐ Integrated

Designation List:

		Name	Certificate Status	Start Date	End Date

DOCUMENTATION

Receiving Facility Documentation

Since you have marked this site with interest in applying for a receiving facility designation, the documents that are identified below will help DCF in being most effective at reviewing your designation. These documents will help DCF in making decisions as well as conducting inspections to help them make a decision. Next to each category of document, select the Upload button to upload that type of document. Select the "Upload Documentation Checklist" above to indicate which documents have been uploaded. Navigate to the Documentation tab above to see all documents in one place.

Community Need Documentaton

Please include the community need for maintaining or expanding the present level of service to meet the existing need, and why this applicant is best suited for this purpose.

Protocol on Individual's Rights

Please upload key facility protocols on legal rights of persons served by the facility and providers.

Protocol on Psychiatric Care

Please upload facility protocols on Psychiatric Care.

Protocol on Record Standards

Please upload your documentation on records standards.

Protocol on Complaint Reporting, Investigations and Reviews

Please upload your documentation for complaint reporting, and investigation and reviews.

Complaint and Grievance System Documentation

Please upload your documentation and mandatory time frames about this system.

Complaint and Grievance System Patient and Family Pamphlet

Please upload a copy of the pamphlet used by the facility to educate persons served by the facility and family members about this system.

Protocol on to Prevent Economic Exploitation of or Trafficking of Persons

Please upload your protocols to prevent the organization, its staff, its contractors, and its privileged professionals from economic exploitation of, trafficking persons among facilities for economic purposes or similar activities prohibited by s.817.505, F.S., and related statutes.

How does your facilities provide exercise and daily opportunities for fresh air.

Describe how your facility provides exercise and daily opportunities for fresh air?

Documentation on Low Stimulation or Separate Psychiatric Emergency Recption

Describe the means utilized to create a low stimulation or separate psychiatric emergency reception and triage area that minimizes individual's exposure to undue and exacerbating environment stresses while awaiting or receiving services.

Policies on aftercare or post discharge psychiatric care services

Please upload your facility policies on providing aftercare or post discharge psychiatric care services.

Policies on discharge planning, including continuity of medication availability

Please upload your facility policies on discharge planning, include continuity of medication availability.

Copy of the current AHCA License

Please upload your documentation on....

Most recent Accreditation Survey Report

A copy of the most recent Accreditation survey (A copy of the facility's corrective action response associated with this report should be a supplemental document)

Certificate of Good Standing - Department of State

Please upload your documentation on....

Documentation from Governing Board Authorizing Designation

Please document the reasons.....

Receiving Facility Documentation for Inspections

List of Board Members

Please upload your documentation on....

Facility Organization Chart

Please upload your documentation on....

Document identifying populations served

Please document the reasons.....

Receiving Facility Employee Roster

A copy of a current receiving facility employee roster, with indication to those staff that perform emergency reception and screening.

Handbook

Please document the reasons.....

Activity Schedule

Please upload your documentation on....

Complaint and Grievance Log for prior 12 Months

Please document the reasons.....

Facility's Incident Tracking Log

Please upload your documentation on....

Facility's Seclusion and Restraint log

Please document the reasons.....

Most recent AHCA Survey

A copy of most recent AHCA survey (A copy of the facility's corrective response associated with this survey should be a supplemental document)

Provider ID:

ADMIN ONLY

Only visible to HQ Staff

Admin Override ☐

SALIS Provider ID:

SALIS Site ID:

PROV-001907 Rev 5

Close

Provider Profile | Provider Documents | Related Documents | Related Forms | Change Log | History | Revisions | Workflow

Save as PDF... Print Preview

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PROVIDER PROFILE

ACTIONS AND STATUS

The following are actions that you can take for this provider.

Provider Status: Creating Profile

Provider ID: PROV-001907

Circuit/Region: Select Ite Select Item

DCF Actions

Re-Enable Profile — Selecting this button enables the profile. You will need to enable user accounts for the users who should administer this provider profile.

Queue to Move Components — Select the button to the left in order to move all of the components, sites, and other related records to a new provider. Select the New Provider then select the Queue to Move Components. The migration will then be scheduled to occur shortly. Once the migration is completed, the Records Moved checkbox will be marked.

New Provider ID: Select Item

Move Records to New Provider: ☐ Records Moved: ☐

Technical Assistance Request — Select this button every time that technical assistance is requested. This will help to identify the burden of the new system in supporting providers.

Number of Times Technical Assistance is Requested:

SERVICE PROVIDER INFORMATION

For providers with multiple sites, enter corporate headquarters information.

Service Provider Legal Name (Enter legal name filed with the State of Florida)
3rd Step Recovery Group, Inc

Change Identifying Information: ☐

Doing Business As:
Continental Wellness Center

Federal Employer Identification Number (FEIN): 27-1656201

NPI Number: 1104156249

Corporate Mailing Street: PO Box 14303 Room/Suite:

City: Ft. Lauderdale

State: FL

Zip Code: 33302 County:

Corporate Physical Address is the same as the mailing address? Different

Corporate Physical Street: 450 NE 44 Street Room/Suite:

City: Oakland Park

State: FL

Zip Code: 33334 County:

Corporate Phone Number: (954) 462-4599

Corporate Fax Number: (954) 761-7740

Legal Entity/Program Website:

Type of Legal Entity: Profit

Type of "For Profit" Entity: Corporation

Entity Number: P10000003648 Filing Date with Secretary of State: 1/11/2010

State Incorporated: FL Select to Upload Articles of Incorporation (1)

Please select applicable boxes:

- [ ] Private Practitioner
- [ ] Faith-Based Provider
- [ ] Community Substance Abuse Coalition

Is this agency incorporated with the State of Florida? Select Item

Do you accept one of the following? (Select all that appy.)

- [ ] Medicaid
- [ ] Medicare
- [ ] Indigents

Save

SITE INFORMATION

Please select the button in this section to create a site for each location where you do business and where you will want to request a new service component. To edit any site, select the edit link next to the site.

Add a New Site

Site Name	Site Status	Physical Address	Suite

MANAGEMENT AND CONTACT INFORMATION

Please select the button in this section to add management and contact information to your organization. You need at least one employee marked as the Owner, CEO, CFO and Training coordinator before you will be allowed to add any service components to a site. You can also add employees who are the contact for each site. You are not required to enter every employee.

Add New Management

		Last Name	First Name	Owner	CEO	CFO	Profil...	Employee Status	
View	Edit	Freeman	Maria				✔	Active	✔

DOCUMENTATION

In order for you to apply for various service components, you need to upload supporting provider documentation. Select the upload buttons below to upload each type of electronic file. Once you have uploaded appropriate documentation and created sites, you can request service components in each of your site profiles. Select the "Update Documentation Checklist" button below to update the checkmarks next to each document uploaded. Navigate to the Documentation tab at the top of this screen to view the documents you have uploaded.

Check Remaining Documents

Save

Upload (1)

Agency Information

Provide information that establishes the name and address of the applicant.
- Information that establishes the provider's Chief Executive Officer (CEO)
- The name of each member of the applicant's board (if a corporation)
- The names of any officers of the corporation
- The names of any shareholders

Upload (1)

Provider CEO Information

Provide documentation of the competency and ability of the applicant and its CEO to carry out the requirements of Chapter 65D-30, F.A.C.
This includes, but is not limited to: Curriculum Vitae, Resume or Credentials

Note: Inmate Programs operated within Department of Corrections' facilities, or contracted to the Department of Management Services, are exempt from this requirement.

Upload (0)

Financial Viability

Provide proof of financial ability and organizational capability to operate in accordance with Chapter 65D-30, F.A.C.

Note: Inmate Substance Abuse Programs operated directly by the Department of Corrections are not required to submit this information.

Upload (0)

Policy and Procedure Manual

Provide a copy of the applicant's indexed Policies and Procedures which show compliance with Common Licensing Standards, and programmatic operating procedures.

Upload (0)

Current Organization Chart

Include the current organizational chart, with staff names, titles, and credentials.

Upload (1)

Level 2 Background Screening

Provide level 2 fingerprinting and background screening information, and include ORI/identifier number from the DCF Regional Background Screening Coordinator for: Owners, Chief Executive Officer (CEO), and Chief Financial Officer (CFO)

Note: See http://www.dcf.state.fl.us/programs/backgroundscreening/ (http://www.dcf.state.fl.us/programs/backgroundscreening/) to find the DCF Regional Background Screening Coordinator nearest you. (Re-screen applicable staff every five years).

Upload (0)

Local Law Enforcement Check

Provide the results of the local law enforcement check for: Owners, Chief Executive Officer (CEO), and Chief Financial Officer (CFO)

Note: The licensee must re-screen applicable staff every five years, in the person's county of residence.

Upload (0)

Treatment Resource Attestation

Provide the treatment resource attestation as proof of fingerprinting for:
Staff and volunteers who have direct contact with individuals under the age of 18 and adults who are developmentally disabled.

Note: The form may be located at the following address:
http://www.dcf.state.fl.us/programs/samh/SubstanceAbuse/docs/treatmentresource.pdf
(http://www.dcf.state.fl.us/programs/samh/SubstanceAbuse/docs/treatmentresource.pdf)

Upload (1)

Affidavit of Good Moral Character

Provide the notarized statement of good moral character for owner(s), CEO(s), and CFO(s).

Note: The form may be located at the following address:

http://www.dcf.state.fl.us/programs/backgroundscreening/forms.shtml
(http://www.dcf.state.fl.us/programs/backgroundscreening/forms.shtml)

Save

Computerized Application for Licensure to Provide Substance Abuse Services, CF-MH 4024A, August 24, 2012 [65D-30.0034, F.A.C.].

Admin Override

Admin Save

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COMPONENT REQUEST

PROGRAM INFORMATION

Component Request ID: Component Request

Request Type: Select Item

Program Name:

Component Requested: Select Item

COMPONENT STATUS & ACTIONS

Related Invoice Information:

☐ Invoiced: Invoice Number:

Invoice Unique ID:

Read Only

License State: Select Item

Review Status: Select Item

Provider ID:

Site ID:

Site Address:

Region: Select Item

Circuit: Select Item

Certificate Status: Not Ready

Inspection Status: Not Required

Key Dates

Submission Date:

Effective Date:

Expiration Date:

DCF Response Due:

Provider Response Due:

Provider Response Extension:

Renewal Notifications

120 Day:		90 Day:		60 Day:		30 Day:	
120 Day Sent	☐	90 Day Sent	☐	60 Day Sent	☐	30 Day Sent	☐

☐ Integrated Facility

Is the applicant accredited by a certifying organization approved by the department? Select Item

Name of Training Coordinator:

Name of Medical Director: License Number:

Primary Funding Source

Primary funding source affects fee calculation.
Select Item

Multiple Funding Sources

If this component has multiple funding sources please select all applicable sources of funding for THIS component:

- ☐ Publicly Funded
- ☐ Privately Funded
- ☐ DCF Contracted

Hours during which the program is open:

Monday	Select Item	AM	to	Select Item	PM	☐ Closed
Tuesday	Select Item	AM	to	Select Item	PM	☐ Closed
Wednesday	Select Item	AM	to	Select Item	PM	☐ Closed
Thursday	Select Item	AM	to	Select Item	PM	☐ Closed
Friday	Select Item	AM	to	Select Item	PM	☐ Closed
Saturday	Select Item	AM	to	Select Item	PM	☐ Closed
Sunday	Select Item	AM	to	Select Item	PM	☐ Closed

Have all staff and volunteers who have direct contact with individuals under the age of 18 years been finger printed and screened in accordance with section 397.451(1)(a), Florida Statutes? Select Item

Please check the population, which have been targeted for services.

- ☐ White (Non-Hispanic)
- ☐ Black (Non-Hispanic)
- ☐ Hispanic
- ☐ American Indian
- ☐ None
- ☐ Other

Please list any special population group targeted for services (e.g., hearing impaired, pregnant alcoholics or addicts, youth, criminal justice clients, etc.)

- ☐ Children
- ☐ Women
- ☐ Adolescents
- ☐ Homeless
- ☐ HIV/AIDS
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Older Adults

What is the maximum number of individuals that can be served in this component on a given day?

What is your projected operating budget for the component listed on this application for the current year?

Please list the complete names of agencies or practitioners you have written referral agreements, contracts, or subcontracts with and check the type of business relationship:

		Name	Type of Agreement

Please list the sources of revenue you receive by name and check the type of funds, e.g., state funds, federal funds, fees, etc:

		Name of Organization	Source Type

Please further describe your program listed in item at the top of the screen. **For counseling programs, this information should include the number of counseling sessions provided weekly, the duration of each counseling session, and the average length of stay in the program.**

☐ Criminal Justice-Involved Adults
☐ Juvenile Justice-Involved Youth
☐ Pregnant and Post Partum Women
☐ Pregnant and Post Partum Adolescents
☐ Co-occurring
☐ Intravenous Drug Users
☐ Other

Signature of the Chief Executive Officer (Original signature only)

Signature Stamp

DCF ADMINISTRATION SECTION

Fee values below are populated when invoice is generated

License Fees: OCA Code:

Late Fee:

Amount Due:

This request will not be processed until payments are received.

Payment Received: Not Received

Please verify evidence of compliance for applicable areas below (including the expiration date) then mark valid documents that have been uploaded:

	Compliant	Expiration Date	Documentation Verified
Fire and Safety	Select Item		☐
Zoning Compliance	Select Item		☐
Property Insurance	Select Item		☐
Professional Liability Insurance	Select Item		☐

Assigned Specialist/Regional Lead: Select Item

COMPONENT ADMINISTRATIVE ACTIONS

Regional Director Signature

Signature Stamp

Select this button to request denying the license for this provider. Your request will be routed to the regional director for approval.

FOLLOW-UP, REMINDERS

	Assigned User	Reminder Date	Reminder Notes

COMMUNICATIONS LOG

	Date of Comm...	Type of Communic...	Sender Name	Notes

CEO User for Workflow: Select Item

Admin Override ☐