STATE OF COLORADO
DEPARTMENT OF HUMAN SERVICES
OFFICE OF BEHAVIORAL HEALTH

APPLICATION FOR CLINIC DESIGNATION
FOR THE PROVISION OF MENTAL HEALTH SERVICES
SECTION 27-66-101, C.R.S.

PLEASE TYPE OR LEGIBLY PRINT INFORMATION

NAME OF FACILITY ____________________ PHONE (___) ____________________
(As it should appear on certificate)
FAX (___) ____________________

ADDRESS
____
NUMBER STREET

____
CITY COUNTY ZIP CODE

CONTACT PERSON ____________________ TITLE ____________________

EMAIL____________________ PHONE ____________________

*****Mailing Address*****____________________
(if different than address identified above)

SITE REVIEW LIAISON ____________________ TITLE ____________________
(If different than contact person above)

EMAIL____________________ PHONE ____________________

CLINIC AND SPECIAL POPULATION DESCRIPTION:
____

HOURS OF OPERATION____________________

TARGET POPULATION (estimate numbers the clinic will serve this year)
Check all that apply:

- ❑ NUMBER OF YOUNG CHILDREN (AGES 0 – 5) ____
- ❑ NUMBER OF CHILDREN (AGES 6 -11) ____
- ❑ NUMBER OF ADOLESCENT (AGESS 12 –17) ____
- ❑ NUMBER OF ADULTS (AGES 18 – 59) ____
- ❑ NUMBER OF OLDER ADULTS (AGES 60+) ____

SIGNER MUST HAVE THE LEGAL CAPACITY AND AUTHORITY TO DO SO, AND SIGNATURE MUST BE NOTARIZED

SIGNATURE ____________________ DATE ____________________

TITLE ____________________

NOTARIZED	FOR OFFICIAL USE ONLY
COUNTY OF ____________________	PROVISIONAL APPROVAL ____________________ (See attached letter) (Date)
STATE OF COLORADO **SUBSCRIBED AND SWORN TO BEFORE ME**	APPROVED ____________________
THIS ________ **DAY OF** ________ **, 2** ________ **WITNESS MY HAND AND OFFICIAL SEAL**	EFFECTIVE DATE ____________ TO ____________ SIGNED ____________________
DATED AT ____________________ **, COLORADO**	TITLE Director, Quality Assurance and Standards
SIGNED ____________________	DATE ____________________

Please return to**: Office of Behavioral Health, Attn**: **Kelly Creinin, 3824 W. Princeton Circle, Denver, CO 80236**
Rev. Date 03/2013