FACILITY FACTS RECORD

State Form 48160 (R5 / 3-13)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION
CERTIFICATION AND LICENSURE
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739

INSTRUCTIONS:
1. *Complete form for each facility*
2. *Forward to address in upper right corner of form.*

One form must be completed for each location where treatment services are provided. This form **must be submitted** when requesting a certification or license or a renewal of them. This **form must also be submitted** when adding a facility setting or service or discontinuing use of a facility location or a service. Such **changes must be reported within thirty (30) days of the change**. This blank form may be duplicated. Please keep a copy of this form on file to report facility or service changes throughout the certification/license period.

1. General Information

Legal Name of Applicant Agency	
Check all that apply to this facility:	☐ Operated by applicant agency
☐ NEW Setting (**Effective Date** *(month, day, year)*: _____)	☐ NEW Service(s) (**Effective Date** *(month, day, year)*: _____)
☐ Discontinued Setting (**Effective Date** *(month, day, year)*: _____)	☐ Discontinued Service(s) (**Effective Date** *(month, day, year)*: _____)
Name of facility	
Location address of facility Number and street	
City, state, ZIP code, and county	
Telephone Number	

2. Array of Services

Applicants must indicate all services provided or discontinued at this location. *Check all that apply.*

☐ Individual Treatment Planning	☐ Acute Stabilization	☐ Residential Services
☐ Outpatient Services	☐ Detoxification Services	☐ Family Support Services
☐ Intensive Outpatient Services	☐ Medication Evaluation and Monitoring	☐ Inpatient Care and Treatment
☐ Day Treatment	☐ Case Management	☐ Opioid Treatment Facility
☐ 24 Hour a Day Crisis Intervention		☐ (Opioid) Addiction Treatment Facility

3. Fire, Health, and Safety Documentation

Documentation must be maintained by the applicant agency. Private Mental Health Institutions (Inpatient), Subacute settings, and Supervised Group Living Facilities must be inspected by the State Fire Marshal per request from the Division.

Fire and Safety	Date of last fire/safety inspection *(month, day, year)*:
Agency conducting fire/safety inspection	
Result: ☐ without violation	☐ with violation ***(Attach Plan of Correction)***
Health and Sanitation *(Does NOT apply to Outpatient settings.)*: Date of last health inspection *(month, day, year)*:	
Agency conducting health inspection	
Result: ☐ without violation	☐ with violation ***(Attach Plan of Correction)***

4. Type of Service

Use 'X' or 'YES' to complete the two tables below. Indicate age, gender, population served, and beds at this location.

Table A. 24-Hour Care

Complete the table below.

An applicant must be a certified Residential Care Provider (or deemed Residential Care Provider) to operate a Supervised Group Living Facility, a Subacute Stabilization setting or Transitional Residential setting.

Use 'X' or 'YES' to complete the table below. Indicate age, gender, population served, and beds at this location.

Residential and Inpatient Care	Age **17** and under	Age **18** and over	Gender Male	Gender Female	Mentally Ill	Addiction	Compulsive Gambling	Detox	Total Beds in Facility
Transitional Residential Facility									
Supervised Group Living Facility									
Subacute Stabilization Facility									
Private Mental Health Institution – (Inpatient)									

Table B. Outpatient Treatment, Care, and Rehabilitation

Complete Table B below. Use 'X' or 'YES' to complete the table below. Indicate age(s) and population and service(s) that apply to this location.

Outpatient – Nonresidential	Age 17 and under			Age 18 and over		
	Addiction	Mentally Ill	Compulsive Gambling	Addiction	Mentally Ill	Compulsive Gambling
Outpatient Treatment Services						
Outpatient Detox *						
Opioid Treatment (Dosing)						
Day Treatment/ Partial Hospitalization						

*Requires a separate, signed statement be attached. See "Required Attachments: Addiction Treatment Services 440 IAC 4.4".

5. Agency Identification

Printed Name of person completing the Facility Facts Record	Date *(month, day, year)*	Telephone Number
Email address of person completing the Facility Facts Record		
Legal Name of Applicant Agency		
Facility Location Address ***(do not give Agency Address)***		