# Health Standards Section

**Change of Address Checklist for Behavioral Health Service Provider (BHSP**)

**Name of provider:**

## \*\*\*YOU MUST TURN IN YOUR LICENSE FOR THE PREVIOUS LOCATION\*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria (Each of these must be attached in order for your application to be processed)**: | **Yes** | **No** | **NA** |
| **FNR Approval Letter, only for CPS and/ or PSR services and/ or residential substance abuse that treats anyone other than women and adolescents. Located at:** [**FNR Approval**](https://ldh.la.gov/index.cfm/page/3728) |  |  |  |
| Letter of Intent: Providers licensed by Health Standards Section (HSS) must notify the department of a change of address. All providers having a change of address shall submit a Letter of Intent with the date that the change of address will be effective. |  |  |  |
| A completed BHS provider licensure application. On application, mark “Other” and indicate “Change of Address (list the new address on the application)Located at: [BHS Application](https://ldh.la.gov/assets/medicaid/hss/docs/BHS/HSS-BH-01_Lic-App-February2024.pdf) |  |  |  |
| The non-refundable licensing fee established by statute, copy of the check and completed Transmittal Form. Updated fees are located at [Health Standards Fee Schedule](https://ldh.la.gov/index.cfm/page/252)Mail Payment and Payment Transmittal Form to: DHH Licensing Payments, P.O. Box 734350, Dallas, TX 75373Payment Procedure located at: [Payment Procedure](https://ldh.la.gov/page/hss-payment-procedure)Payment Transmittal Form located at: [Payment Transmittal Form](https://ldh.la.gov/assets/medicaid/hss/docs/ALL_Prgms/PaymentTransmittalForm062019.doc) |  |  |  |
| The LDH plan review approval letter from Office of State Fire Marshal, (OSFM). Has the DH Project number.  |  |  |  |
| The on-site inspection report with approval for occupancy by the OSFM. |  |  |  |
| Cautionary Codes from the Plan Review  |  |  |  |
| Attestation for Compliance from addressing the above Cautionary Codes. [Attestation to Plan Review Cautionary Codes](https://ldh.la.gov/assets/medicaid/hss/docs/BHS/HSS_PR_02PlanReviewAttestation.doc) |  |  |  |
| The health inspection report with recommendation for licensure from the Office of Public Health, (OPH). |  |  |  |
| ***Except for governmental entities, proof of financial viability. Provide verification and continuous maintenance of all of the following pursuant to R.S. 40:2153:*** |  |  |  |
| 1. Proof of professional liability insurance of at least $500,000 or proof of self-insurance of at least $100,000, along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF): a. if the BHS provider is self-insured and is not enrolled in the PCF, professional liability limits shall be $1 million per occurrence/$3 million per annual aggregate.

**NOTE: the LDH-HSS shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent).****Specifically:** LDH Health Standards Section, PO Box 3767, Baton Rouge, La. 70821  |  |  |  |
| 1. Proof of workers' compensation insurance; and

**NOTE: the LDH-HSS shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent).****Specifically:** LDH Health Standards Section, PO Box 3767, Baton Rouge, La. 70821 |  |  |  |
| 1. Proof of general liability insurance of at least $500,000.

**NOTE:** **the LDH-HSS shall specifically be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance by the insurer or producer (agent).****Specifically:** LDH Health Standards Section, PO Box 3767, Baton Rouge, La. 70821 |  |  |  |
|  A legible floor sketch or drawing of the premises to be licensed with documented room dimensions and identified service areas. |  |  |  |
| Rental/Lease Agreement or Proof of Ownership |  |  |  |
| Any other documentation or information required by the department for licensure. |  |  |  |
| Please email all documents (Except actual payment as noted above) to: [HSS-BHSProviders <HSS-BHSProviders@la.gov>](HSS-BHSProviders%20%3CHSS-BHSProviders%40la.gov%3E) |  |  |  |
|  |  |  |  |

*HSS-BH-INITIAL Provider Checklist (10/2024)*

Health Standards Section

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