# Health Standards Section

**Behavioral Health Service Provider (BHSP)**

**Add OFFSITE LOCATION or ADDING a SERVICE Check List (If adding services only submit documents with an asterisk\*\*)**

***Name of Provider:***

**ALL ITEMS BELOW ARE REQURIED FOR UNIT (BEDROOM) AND BED ADDITIONS**

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 indicating location of facility (physical address), # of beds/bed numbers to be added, # of bedrooms/bedroom numbers, location of new beds, if male/female beds, and the total # of beds and bedrooms after the addition.\*\* |  |  |  |
| \*\*A completed BHS provider licensure application. Located at: [BHS Application](https://ldh.la.gov/assets/medicaid/hss/docs/BHS/HSS-BH-01_Lic-App-February2024.pdf) In space for bedrooms & beds, put current number + number of additional bedrooms/beds= TotalIf Adding Substance Abuse/ Addiction services, please submit copy of Addictionologist credentials with contractual agreement. \*\* |  |  |  |
| DH Plan review from OSFM with approval from OSFM. (will have DH-##-###) |  |  |  |
| Cautionary codes from OSFM DH plan review. |  |  |  |
| Attestation for compliance with each of the OSFM DH plan review Cautionary codes. [Attestation to Plan Review Cautionary Codes](https://ldh.la.gov/assets/medicaid/hss/docs/BHS/HSS_PR_02PlanReviewAttestation.doc) |  |  |  |
| Current on-site inspection report from OSFM. |  |  |  |
| Current on-site inspection report from OPH. |  |  |  |
| Copy of offsite floorplan. |  |  |  |
| ***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 |  |  |  |
| Copy of lease agreement or proof of ownership of new location. |  |  |  |
| \*\*Payment of applicable fee. \*\* Please send a copy of the payment transmittal form and copy of check with check number/routing information visible. Updated fees are located at: [Health Standards Fee Schedule](https://ldh.la.gov/index.cfm/page/252)**Payment should be sent to lockbox in Dallas.** DHH Licensing Payments, P.O. Box 734350, Dallas, TX 75373**Payment Procedure located at**: Payment Procedure**Payment Transmittal Form located at:** [Payment Transmittal Form](https://ldh.la.gov/assets/medicaid/hss/docs/ALL_Prgms/PaymentTransmittalForm062019.doc) |  |  |  |
| **NOTE: For residential only. Bed additions require an onsite physical environment survey prior to final approval for licensing/use.** |  |  |  |
| **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 (12/2024)*

Health Standards Section

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