RI Department of Health

Licensing Application
and instructions for

HARM REDUCTION CENTERS
RI General Law Chapter 23-12.10

Licensee Name: _____

Licensee Number: _____
(Assigned by DOH)

Initial Licensure: Please check which license type(s) you are applying for.

☐ **On-site Premises** *(Premises means a tract of land and the buildings thereon where direct patient care services are provided).*

☐ **Mobile Unit** *(Means a Harm Reduction Center that can move location, such as a van or a bus).*

☐ **Short Term Unit** *(less than one hundred eighty 180 days - means a Harm Reduction Center or component of a Harm Reduction Center thereof that does not have a permanent, fixed location, such as a tent.)*

State of Rhode Island
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- There is no fee for this application.
- Sign the completed application, return it with the required attachments and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097

- If you have any questions concerning this application, call the **Center for Health Facilities Regulation** (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.
- Provider is required to comply with all licensure requirements per 216-RICI-40-10-25 (Licensing of Harm Reduction Centers). (link is pending)
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You must attach a printed current list of all direct and indirect owners whether individual, partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Other requirements required prior to approval:

- State Fire Marshall's Life/ Fire Safety approval
- Municipal Authorization and Approval
- Certificate of Occupancy from local Fire Department

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

State of Rhode Island
Department of Health

Please complete the following:

License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Medical Director Information: Please provide the name of the Medical Director for this center. **NOTE: This section must be completed as a requirement of your license renewal**	Name: _____ License Number: _____
Licensed Capacity What is the number of drug consumption stations at this site	☐

Director: Please provide the name of the individual responsible for administrative operation of the Harm Reduction Center	Name _____ Title _____ Phone number: _____ E-mail address: _____
Program Name: Please provide the name of the program (as known to the public) .	Name _____

Program Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____
Program Location Information: Please provide the location information for this center. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone _____ Fax _____ Email Address _____

Ownership Information: Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name _____ DBA _____
Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code _____ Phone _____ Fax _____ Email Address _____

Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the center control	Corporation Type _____ Name of Organization_____ Address Line 1_____ Address Line 2_____ Address Line 3_____ Address City, State, Zip Code_____ Phone_____ Fax _____ Email Address _____

Acknowledgements

I am aware of Chapter 23-1-52 of the General Laws of Rhode Island, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-1-52 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number: **(Federal Employer Identification Number)** **Note: If you are a sole proprietor this number may be your Social Security Number.**	**Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.** Please provide below SSN/FEIN for this license: SSN/F.E.I.N. Number: _____
Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.** _____ _____ **Signature of Authorized Person** **Date of Signature (MM/DD/YY)** _____ **Printed Name of Authorized Person** _____ **Title of Authorized Person** **Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.**