

**Texas Department of State Health Services
Substance Abuse Facility Closure Information**

Complete a form for each closed program site.

Date: _____

To: Texas Department of State Health Services
Regulatory Licensing Unit
Facility Licensing Group-Mail Code 2835
P.O. Box 149347
Austin, TX 78714-9347

From: _____

Print/Type first & last name, title

Print/Type Facility Name

Print/Type HQ Mailing address

Print/Type City, State & ZC

Re: Facility Closure: License Number(s): _____

Program Site Physical Address, City: _____

I attest that the following steps have been completed:

(Please check the following items, sign and date)

- The Department's certificate(s) of licensure has/have been returned, or is/are enclosed.
- Appropriate transfers and referrals have been made for all active clients remaining in the program(s) at the time of closure.
- Arrangements have been made for the confidential disposition of client records.
- All applicable regulatory and funding authorities have been notified of the facility's closure.
- All outstanding fees (if applicable) have been paid in full to the Department.
- Contact person in charge of the client records:

Name: _____ Address: _____

Phone Number: _____ Storage Location: _____

Form Completed by: _____
Print/Type Name Phone Number

Signature Date

Revised 3.2010