

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**  
Bureau of Health Systems  
Division of Licensing & Certification  
Substance Abuse Licensing Section  
P.O. Box 30664  
Lansing, Michigan 48909

**DIRECTIONS FOR COMPLETING THE APPLICATION  
FOR LICENSURE AS A SUBSTANCE ABUSE PROGRAM**

**ALL APPLICANTS**

Complete the standard license application **UNLESS** application or renewal is only for prevention services. Prevention-only applicants are to complete that application.

**WAIVER REQUESTS**

Applicants who want to request a waiver of any licensing rule for the first time must complete the Appendix A form. If you presently have a waiver and wish to renew the request, complete the "Waiver Renewal Only" portion on the bottom of page 4 of the application.

**APPROVED SERVICE PROGRAM/RESIDENTIAL SUB-ACUTE DETOXIFICATION**

Applicants providing residential substance abuse services who wish to be designated as an "Approved Service Provider" or licensed to provide "Residential Sub-Acute Detoxification" are to complete the Appendix B form and submit it with the white application.

**P.A. 309 SCREENING AND ASSESSMENT PROVIDER**

To be designated as a screening and assessment provider under P.A. 309, you must be licensed for Casefinding-Screening, Assessment, Referral, and Follow-Up (SARF) and complete the Appendix C form and submit it with the white application.

Questions pertaining to the submission of any of the above-mentioned forms can be answered by contacting the Substance Abuse Licensing Section (SALS) at (517) 241-1970.

## DEFINITIONS OF TERMS IN THE LICENSE APPLICATION\*

### LICENSED SERVICE CATEGORIES

Prevention - Services that reduce the risk that an individual will develop problems which might require that he or she enter the substance abuse treatment system.

Prevention-CAIT - A prevention service that provides at least one of the following services:

Prevention-Community Change - Planned efforts which are designed to change specific conditions so as to reduce the probability that substance use problems will occur among residents of the community.

Prevention- Alternatives - Providing planned non-treatment personal growth activities which we designed to help a participant meet his or *her* own Personal needs *and* to reduce him or her risk of developing problems which might require that he or she enter the substance abuse treatment system.

Prevention-Information - Providing information to the public which is designed to reduce the risk that an individual will develop problems which might require that he or she enter the substance abuse treatment center.

Prevention-Training - Providing activities which we designed to improve the personal and social skills of a person who wishes to avoid substance use problems or who is in a position to help others avoid problems with substance use.

Casefinding - The process of systematically interacting with the community for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter the service delivery system.

Casefinding-Screening, Assessment, Referral, and Follow-Up (SARF) - Means the performance of a range of activities necessary to make preliminary assessments of problems. The object of these activities, which may include interviews, psychological tests, and other diagnostic or assessment tools, is to effect referrals to appropriate treatment or assistance resources if indicated.

Treatment - An emergency, outpatient, intermediate, or inpatient service and care, and may include diagnostic evaluation, medical, psychiatric, psychological, social service care, and referral services which may be extended to an individual who is or appears to be incapacitated.

Outpatient Care - Scheduled, periodic care, including diagnosis and therapy, in a non-residential setting. Correctional institutions are considered non-residential settings.

Methadone Treatment - Chemotherapy using the drugs methadone or LAAM (levo-alpha- acetylmethadol) as rehabilitation tools in conjunction with other treatment and rehabilitation care.

Inpatient Care -Substance abuse treatment services that are provided to a person within a hospital setting under medical supervision. Inpatient care may include both emergency services and non-emergency services. Inpatient care is provided in hospitals operated by the Department of Mental Health or in beds licensed by the Michigan Department of Community Health.

Residential Care - Substance abuse services that are provided in a full or partial residential setting. Such services may be supplemented with diagnostic services, counseling, vocational rehabilitation, work therapy, or other services which are judged to be valuable to clients in a therapeutic setting. Residential care is not provided in beds also licensed by the Michigan Department of Community Health.

## **ADDITIONAL CATEGORIES ASSOCIATED WITH EXISTING OUTPATIENT, METHADONE CLINIC AND/OR RESIDENTIAL LICENSE**

Case Management - A substance use disorder case management program that coordinates, plans, provides, evaluates and monitors services for recovery from a variety of resources on behalf of and in collaboration with a client who has a substance use disorder. A substance use disorder case management program offers these services through designated staff working in collaboration with the substance use disorder treatment team and as guided by the individualized treatment planning process

Early Intervention - A specifically focused treatment program including stage-based intervention for individuals with substance use disorders as identified through a screening or assessment process including individuals who may not meet the threshold of abuse or dependence.

Integrated Treatment for Persons with Mental Health and Substance Use Disorders - A program that offers and provides both substance use disorder and mental health treatment in an integrated manner as evidenced by staffing, services and program content. The program is designed for individuals determined through an assessment process to have both distinct substance use and mental health disorders. Services must be provided through one service setting and through a single treatment plan and represent appropriate clinical standards including stage-based interventions. Programs that focus primarily on one disorder but are able to address the interaction between the disorders and/or coordinate services with other providers do not require a service category license as an integrated treatment program.

## **ADDITIONAL CATEGORIES ASSOCIATED WITH EXISTING OUTPATIENT, METHADONE CLINIC, RESIDENTIAL AND/OR PREVENTION LICENSE**

Peer Recovery and Recovery Support - Programs that are designed to support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery and offer social emotional and/or educational supportive services to help prevent relapse and promote recovery.

## **TYPE OF CARE NEEDED BY CLIENT**

**Acute Care** - Acute substance abuse treatment is for conditions that are life-threatening due to intoxication with alcohol or other drugs or chemicals. Acute care is physician directed/supervised medical care in an inpatient setting.

**Sub-acute Care** - Sub-acute substance abuse treatment is for conditions that are not life-threatening but require a coordinated treatment program which may include detoxification, individual and group counseling, chemotherapy, medical care or other appropriate services deemed necessary by the professional supervised treatment staff.

## **TYPE OF CARE PROVIDED BY PROGRAM**

**Detoxification** - Detoxification treatment means a medically acute or sub-acute systematic reduction of the amount of a drug in the body, or the elimination of a drug from the body concomitant with supportive treatment services. Detoxification typically lasts 3-5 days. Inpatient programs provide acute detoxification services typically lasting 3-5 days in hospital beds licensed by the Michigan Department of Community Health. Residential-Approved Service programs and others provide sub-acute detoxification services typically lasting 3-5 days.

**Rehabilitation** - The act of restoring an individual to a state of mental and physical health or useful activity through vocational or educational training, therapy, and counseling.

**Intermediate Care/Rehabilitation** - Programs which typically do not exceed 45 days in duration. Such residential/inpatient programs have an organized treatment staff supervised by a master's degree (or equivalent) professional responsible for overall quality of clinical care. Planned individual or group treatment services typically do not exceed 30-45 days duration. Intermediate care may be delivered in delicensed or off-line inpatient beds.

**Long-Term Therapeutic Community** - A long-term residential program that is structured as a drug-free living situation in which the primary therapeutic tool is the supportive or confrontive peer interaction of the residents. Individual and group counseling are built into structured daily routines. Treatment typically exceeds 60 days.

**Long-Term Halfway House** - An establishment with administrative supervision that provides -- through permanent facilities and guidance personnel -- resident beds, structured or supervised peer group living, and limited health-related services emphasizing social rehabilitation with support and guidance toward the goals of independent living for its residents, who have problems related to substance abuse. Halfway house care typically lasts six months or more.

\*See Public Act 368 of 1978, as amended, Article 6 and Rules for full set of definitions.

<p align="center"><b>Michigan Department of Community Health</b> Substance Abuse Licensing Section</p> <p align="center"><b>APPLICATION FOR A SUBSTANCE ABUSE LICENSE</b></p>	<p>Check all <input type="checkbox"/> MASTER SITE that apply: <input type="checkbox"/> SATELLITE LOCATION <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL</p> <p>LICENSE NUMBER: _____ CA NUMBER: _____ CONSULTANT: _____ DATE DUE: _____</p>
<p>RETURN THIS <b>ORIGINAL</b> APPLICATION TO:</p> <p>Michigan Department of Community Health Bureau of Health Systems Division of Licensing &amp; Certification Substance Abuse Licensing Section P. O. Box 30664 Lansing, Michigan 48909</p>	<p><b><i>Mail copy of Application to the Regional Coordinating Agency listed on page 12 which corresponds with the "CA Number" listed above.</i></b></p>

In accordance with the provisions of Act 368 of the Public Acts of 1978, as amended, and the Administrative Rules (R 325.14101-R 325.14928) of the Michigan Department of Community Health, Substance Abuse Licensing Section, the undersigned hereby applies for a license to operate a substance abuse treatment, rehabilitation and/or prevention program.

DATE SUBMITTED \_\_\_\_\_

PROGRAM LEGAL NAME \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

P.O. BOX (If applicable) \_\_\_\_\_ COUNTY \_\_\_\_\_

CITY \_\_\_\_\_ MI, Zip \_\_\_\_\_ PHONE \_\_\_\_\_ / \_\_\_\_\_  
AREA CODE

E-MAIL \_\_\_\_\_ FAX# \_\_\_\_\_

INDICATE THE TYPE OF ORGANIZATION THAT IS LEGALLY RESPONSIBLE FOR OPERATION OF THE PROGRAM. PLEASE COMPLETE BOTH PARTS A AND B.

- |   |  |  |
|---|--|--|
| <p>A. <input type="checkbox"/> For Profit<br/><input type="checkbox"/> Non-Profit</p> | <p>B. <input type="checkbox"/> Sole Ownership<br/><input type="checkbox"/> Corporation<br/><input type="checkbox"/> Partnership<br/><input type="checkbox"/> City Government</p> | <p><input type="checkbox"/> County Government<br/><input type="checkbox"/> State Government<br/><input type="checkbox"/> Hospital Authority<br/><input type="checkbox"/> Other-Specify<br/>_____</p> |
|---|--|--|

DAYS/HOURS OF OPERATION: \_\_\_\_\_

PROGRAM DIRECTOR'S NAME: \_\_\_\_\_

## LICENSED SERVICES AND CAPACITY

For this program, indicate the service (s) for which licensure or special designation is requested. The terms used are defined in the Administrative Rules (R 325.14101 to R 325.14103) and on page two.

### PREVENTION

Community Change, Alternatives, Information, Training

Check if classes are offered: (1)\*  Highway Safety Education  Other Classes

### CASEFINDING

Screening, Assessment, Referral

### OUTPATIENT

Alcohol and Drug Free (Non-Day Care)

Methadone (2)\* Must request Methadone Application

Day Care

### RESIDENTIAL

Sub-Acute Detoxification Number of Beds (3)\* \_\_\_\_\_

Must submit Appendix B (attached)

Intermediate Care

### INPATIENT

MDCH Licensed Beds (4)\* \_\_\_\_\_

License # \_\_\_\_\_

Long-Term Therapeutic Care

Long-Term Halfway

Number of Beds (3)\* \_\_\_\_\_

### SPECIAL DESIGNATION

Screening and Assessment Agent (Drunk-driving court referrals) (5)\*

Must submit Appendix C (attached)

### **CATEGORIES ASSOCIATED WITH OUTPATIENT, METHADONE CLINIC OR RESIDENTIAL (6)\***

Substance Abuse Case Management

Integrated Treatment for Persons With Mental Health and Substance Use Disorders

Early Intervention

### **CATEGORIES ASSOCIATED WITH OUTPATIENT, METHADONE CLINIC, RESIDENTIAL OR PREVENTION PROGRAM (6)\***

Peer Recovery and/or Recovery Support Programs

### REQUEST FOR WAIVER OF RULE

New Requests for Waiver of a Licensing Rule

A separate waiver request form must be completed. Must submit Appendix A (attached).

Waiver Renewal Only

Cite rule number for which waiver request has been granted by the Substance Abuse Licensing Section and for which a renewal is being requested. Rule # \_\_\_\_\_ Rule: \_\_\_\_\_

\*See Explanatory Footnotes on page 7

## EXPLANATORY FOOTNOTES - FOR PAGE SIX (6) OF APPLICATION

- (1) Check if substance abuse/alcohol highway safety education or other classes are offered by the program on a routine basis.
- (2) Programs that utilize controlled substances, including methadone, must complete a separate State Methadone Approval Application (BHS/L&C-103).
- (3) If substance abuse beds are part of a unit which also provides beds for non-substance abuse clients, estimate the number of substance abuse beds, using the maximum beds which substance abusers would fill at any point in time.
- (4) Required if substance abuse beds are licensed by the Department of Community Health typically as medical/surgical beds or as psychiatric beds. Indicate license number.
- (5) An application for designation must be filed - complete Appendix C. A license for Screening, Assessment, Referral and Follow-Up (SARF) is required. Criteria additional to licensing standards must also be met by applicant.
- (6) These categories presuppose an existing outpatient, methadone clinic or residential license. For peer recovery/recovery support, an existing prevention license is also acceptable.

## SATELLITE LOCATIONS

A program that operates in more than one location (site) must list the names and addresses of all sites operating under the same governing authority in the space provided below as well as the service categories at each site. The **Master Site** is the location which provides direct substance abuse services and where all administrative functions are located. This site is determined by the program, not Michigan Department of Community Health. If the administrative office does not provide services, this location should be indicated below.

**MASTER SITE:**                      LICENSE # \_\_\_\_\_ Telephone # \_\_\_\_\_

Name of Program \_\_\_\_\_ Program Director \_\_\_\_\_

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**LICENSE #** \_\_\_\_\_  
Service Category \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Name of Program \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip \_\_\_\_\_ County \_\_\_\_\_ Telephone# (    ) \_\_\_\_\_  
Site Director \_\_\_\_\_ Number of therapists: \_\_\_\_\_  
Average Client Population: \_\_\_\_\_ Avg. Monthly Client Population: \_\_\_\_\_

**LICENSE #** \_\_\_\_\_  
Service Category \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Name of Program \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip \_\_\_\_\_ County \_\_\_\_\_ Telephone# (    ) \_\_\_\_\_  
Site Director \_\_\_\_\_ Number of therapists: \_\_\_\_\_  
Average Client Population: \_\_\_\_\_ Avg. Monthly Client Population: \_\_\_\_\_

**LICENSE #** \_\_\_\_\_  
Service Category \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Name of Program \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip \_\_\_\_\_ County \_\_\_\_\_ Telephone# (    ) \_\_\_\_\_  
Site Director \_\_\_\_\_ Number of therapists: \_\_\_\_\_  
Average Client Population: \_\_\_\_\_ Avg. Monthly Client Population: \_\_\_\_\_

**LICENSE #** \_\_\_\_\_  
Service Category \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Name of Program \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip \_\_\_\_\_ County \_\_\_\_\_ Telephone# (    ) \_\_\_\_\_  
Site Director \_\_\_\_\_ Number of therapists: \_\_\_\_\_  
Average Client Population: \_\_\_\_\_ Avg. Monthly Client Population: \_\_\_\_\_

**LICENSE #** \_\_\_\_\_  
Service Category \_\_\_\_\_

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Name of Program \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip \_\_\_\_\_ County \_\_\_\_\_ Telephone# (    ) \_\_\_\_\_  
Site Director \_\_\_\_\_ Number of therapists: \_\_\_\_\_  
Average Client Population: \_\_\_\_\_ Avg. Monthly Client Population: \_\_\_\_\_



## ACCREDITATIONS, LICENSES AND/OR APPROVALS

Please indicate below all accreditation, licenses, and/or approvals that have been obtained or are being sought for the program. If the approval, license, or accreditation is under a name different from that listed for the substance abuse license, please give the name under which the other license is issued. **PLEASE SUBMIT DOCUMENTATION OF CURRENT ACCREDITATION.**

Program Name \_\_\_\_\_

LICENSE	APPLIED	APPROVED	EXPIRATION DATE	PROVIDER NUMBER
American Osteopathic Association (AOA)	( )	( )	_____	_____
Blue Cross/Blue Shield, Approved Substance Abuse	( )	( )	_____	_____
Blue Cross/Blue Shield. Outpatient Psychiatric Clinic (OPC)	( )	( )	_____	_____
Commission on Accreditation of Rehabilitation Facilities (CARF)	( )	( )	_____	_____
Council on Accreditation of Services for Families and Children (COA)	( )	( )	_____	_____
Department of Social Services, Child Care Institution	( )	( )	_____	_____
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	( )	( )	_____	_____
Medicaid Approved	( )	( )	_____	_____
Medicare Approved	( )	( )	_____	_____
Other- Specify _____	( )	( )	_____	_____

# APPLICATION ATTACHMENTS

## PROGRAM DESCRIPTION

Items A – L as identified below. The attachments must be clearly labeled with the program's 1) name; 2) license number as shown on the front of the application; and 3) date submitted. DO NOT submit copies of your operating procedure manual. We desire a description of the specific policies and procedures called for below. Actual formats used need not be submitted; they will be reviewed at the preliminary licensing inspection. All new applicants MUST SUBMIT ITEMS A - I AND ITEM L. Item L requires that you submit a copy of your notice of intent. This can be a copy of a legal ad from your local newspaper indicating that your program is applying for a substance abuse license OR a copy of a notice which you sent to local churches, schools and incorporated non-profit civic organizations with the names and addresses to whom the notice was sent. Please see sample notice on page twelve (10).

**RENEWAL APPLICANTS:** If the attachments for Items A - I have not changed since your previous submission, check the box that says, "See Prior Application". If an item has changed since your previous application, attach it and mark the box titled "Attached." If your program has a number of sites which are licensed (listed on page 6 of this application), your attachments for the master site MUST describe the services provided at all of your locations, i.e., your admission procedures should describe policies for outpatient, residential, etc.

**A. PROGRAM PHILOSOPHY, GOALS & OBJECTIVES.**

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

**B. TARGET POPULATIONS.** Specify geographic service delivery area and groups toward which services will be directed.

Attached     See Prior Application     New Satellite    Ref. Lic. \_\_\_\_\_

**C. METHODOLOGY.** Describe the methods, procedures and activities used to reach program goals and objectives. Describe individual or group counseling, family therapy, outreach efforts, etc. Prevention programs should indicate the specific activities provided. Describe classes offered (size, content, duration).

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

**D. ORGANIZATIONAL STRUCTURE.** Provide an organizational chart of your program. If part of a larger organization, show relationship.

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

**E. ADMISSION CRITERIA & INTAKE PROCEDURES.** Describe your program's admission/eligibility criteria and intake process and policies. DO NOT submit forms which you use to carry out these processes.

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

**F. DISCHARGE POLICIES & PROCEDURES.** Describe your program's discharge criteria, policies and procedures.

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

N/A

**G. AFTERCARE & FOLLOW UP POLICIES & PROCEDURES.** Describe your program's aftercare services and client follow-up evaluation policies and procedures. If not applicable, please so indicate.

Attached     See Prior Application     New Satellite    Ref. Lic. # \_\_\_\_\_

N/A

H. **RECIPIENT RIGHTS POLICY & PROCEDURES.** Using the “Model Recipient Rights Policy and Procedures” document, develop and submit your program’s recipient rights policies and procedures.

Attached       See Prior Application    New Satellite   Ref. Lic. # \_\_\_\_\_

II. **CONFIDENTIALITY OF CLIENT DATA.** Describe the procedures your program utilizes to assure that all client records are kept confidential. Emphasis should be placed on where client records are stored and measure taken to assure that all records are secure and not available to persons other than staff. DO NOT submit copies of 42 C.F.R.

Attached       See Prior Application    New Satellite   Ref. Lic. # \_\_\_\_\_

J. **ALL RESIDENTIAL PROGRAMS** are to attach evidence meeting fire inspection requirements by fire safety authorities. The inspection must have been performed within the last 12 months.

Attached

K. **RESIDENTIAL PROGRAMS** who provide sub-acute detoxification and/or ASP services MUST complete application (BHS/L&C-105) and submit all required attachments listed therein.

Attached    See Prior Application    New Satellite   Ref. Lic. # \_\_\_\_\_  N/A

L. **NEW APPLICANTS (including new satellites)** must send a NOTICE OF INTENT to churches, schools and incorporated non-profit civic organizations in the program's proposed service delivery area when they intend to provide substance abuse treatment, rehabilitation and/or prevention services. Send a copy of the published notice or evidence that the notice was distributed. SEE EXAMPLE BELOW.

N/A

### EXAMPLE

### NOTICE OF INTENT

(Name and address of applicant program) has applied for a substance abuse license through the Michigan Department of Community Health, Substance Abuse Licensing Section. The license will allow us to provide (type of service to be licensed) substance abuse services. Comments should be directed to (Name and address of coordinating agency).

**ASSURANCES**

As program director, I am responsible to the governing authority of this program or its authorized agent for overall operation of the program. I have reviewed Article 6 of Public Act 368 of 1978, as amended, and the administrative rules applicable to the service(s) provided by this program, I believe my program is in compliance with the rules and the Act and is ready for on-site inspection.

I understand that I may request a waiver of a license rule and that it is my responsibility to complete the appropriate section of the application for a renewal of waiver or to submit a waiver request form for a new waiver request.

I authorize the Chief of the Substance Abuse Licensing Section or his or her representative to obtain from any source, information as to my ability to comply with Article 6 of Act 368 of 1978 as amended, and the Administrative Rules (R 325.14101 - R 325.14928).

I further certify that the information furnished in this application is true and accurate. Any information found to be false may result in my application being denied and my program licensure being revoked. Supportive documentation will be furnished upon request of the Substance Abuse Licensing Section. I have completely filled out this application and understand that if the application is found to be incomplete, the licensing process will be suspended until I have furnished missing or incomplete information.

By signing this application for licensure, I acknowledge that should any information contained in this application change, notice of the change will be immediately provided to the Substance Abuse Licensing Section. Failure to do so may invalidate the license. I understand notice of change of ownership, governing authority or location must be submitted to the Substance Abuse Licensing Section thirty (30) days before the change takes effect. A copy of this application and attachments and subsequent changes to it will be maintained at my program.

A copy of this application and attachments have been sent to the following coordinating agency:

\_\_\_\_\_ on \_\_\_\_\_  
Date

The original application is being submitted to the Substance Abuse Licensing Section.

Signed: \_\_\_\_\_  
Program Director Date

As a member or designee of the applicant program's governing authority, I certify that the governing authority has the authority and responsibility for overall operation of the program and will ensure that the program complies with the applicable licensing standards.

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Printed: \_\_\_\_\_ Title \_\_\_\_\_

## REGIONAL SUBSTANCE ABUSE COORDINATING AGENCIES

- 01. PATHWAYS**  
Substance Abuse Coordinating Agency  
369 U.S. 41 East  
Negaunee, MI 49866-1325  
(906) 226-0035  
**Serving:** Alger, Chippewa, Delta, Luce, Mackinac, Marquette, Menominee, Schoolcraft Counties
- 08. NORTHERN MICHIGAN SUBSTANCE ABUSE SERVICES, INC.**  
1165 Elkview Drive, Ste. 1  
P. O. Box 1278  
Gaylord, MI 49734  
(989) 732-1791  
**Serving:** Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Clare, Crawford, Emmet, Gladwin, Grand Traverse, Isabella, Iosco, Kalkaska, Lake, Leelanau, Manistee, Mason, Mecosta, Midland, Missaukee, Montmorency, Oceana, Osceola, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Wexford Counties
- 09. GENESEE County CMH**  
420 W. Fifth Ave  
Flint, MI 48503  
(810) 257-3201  
**Serving:** Genesee County
- 10. ST. CLAIR COUNTY HEALTH DEPARTMENT**  
Thumb Region Substance Abuse Services  
Coordinating Agency  
3415 – 28<sup>th</sup> St.  
Port Huron, MI 48060  
(810) 987-8922  
**Serving:** Lapeer, Sanilac, St. Clair Counties
- 11. MID-SOUTH SUBSTANCE ABUSE COMMISSION**  
2875 Northwind Drive, Suite 215  
East Lansing, MI 48823  
(517) 337-4406  
**Serving:** Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Jackson, Lenawee, Newaygo, City of Detroit Counties
- 14. KALAMAZOO CO. COMMUNITY MENTAL HEALTH SERVICES,**  
Substance Abuse Services, Regional Coordinating Agency  
Nazareth Complex  
3299 Gull Road, P.O. Box 63  
Nazareth, MI 49074-0063  
(269) 553-8150  
**Serving:** Barry, Branch, Kalamazoo, St. Joseph, Van Buren Counties
- 15. Network 180**  
728 Fuller Ave., NE  
Grand Rapids, MI 49503  
(616) 336-3765  
**Serving:** Kent County
- 20. MACOMB CO. COMMUNITY MENTAL HEALTH**  
Office of Substance Abuse Services  
Macomb County Building, 6th Floor  
10 North Main Street  
Mt. Clemens, MI 48043  
(586) 469-5278 & 469-5920  
**Serving:** Macomb County
- 27. OAKLAND COUNTY HEALTH DIVISION**  
Office of Substance Abuse  
250 Elizabeth Lake Road, Suite 1550  
Pontiac, MI 48341-1050  
(248) 858-0001  
**Serving:** Oakland County
- 28. LAKESHORE COORDINATING COUNCIL**  
324 Washington Street  
P. O. Box 268  
Grand Haven, MI 49417-0268  
(616) 846-6720  
**Serving:** Allegan, Berrien, Cass, Muskegon, Ottawa Counties
- 29. SAGINAW COUNTY HEALTH DEPARTMENT**  
1600 North Michigan Avenue, Ste. 501  
Saginaw, MI 48602-5395  
(989) 758-3745  
**Serving:** Saginaw County
- 33. WASHTENAW COMMUNITY HEALTH ORG.**  
Livingston-Washtenaw Substance Abuse  
Coordinating Agency  
P. O. Box 915  
555 Towner Street  
Ypsilanti, MI 48197  
(734) 544-3000  
**Serving:** Livingston, Washtenaw Counties
- 34. DETROIT DEPARTMENT OF HEALTH**  
Bureau of Substance Abuse  
Herman Kiefer Health Complex  
Main Bldg., Rm. 317, B Wing  
1151 Taylor  
Detroit, MI 48202  
(313) 876-4566
- 35. WESTERN U.P. SUBSTANCE ABUSE SERVICES  
COORDINATING AGENCY**  
902 W. Sharon Ave.  
Houghton, MI 49931  
(906) 482-7710  
**Serving:** Baraga, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Ontonagon Counties
- 40. SOUTHEAST MICHIGAN COMMUNITY ALLIANCE**  
25363 Eureka Rd.  
Taylor, MI 48180  
(734) 229-3500  
**Serving:** Monroe & Wayne Counties
- 41. BAY ARENAC BEHAVIORAL HEALTH**  
Riverhaven Coordinating Agency  
5449 Hampton Place  
Saginaw, MI 48604  
(989) 497-1344  
**Serving:** Arenac, Bay, Huron, Montcalm, Shiawassee, Tuscola Counties