Texas Department of State Health Services
Substance Abuse Facility Closure Information

Date: _____

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

From: Name, Title
Facility
Address
City, State ZIP

Re: Facility Closure: License Number(s):

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:

_____ _____
Signature Date

_____ _____
Print Name Phone Number

Rev. 9.07