Hawaii State Department of Health
Alcohol & Drug Abuse Division
APPLICATION FOR SUBSTANCE USE DISORDER SERVICE AND PREVENTION PROGRAMS

Agency Name:_____ **Date:** _____

Program Name/ASO#:_____

Please select type of program: ☐ Special Treatment Facility ☐ Therapeutic Living Program
☐ Day Treatment ☐ Intensive Outpatient/Outpatient ☐ Detox ☐ Prevention ☐ Opioid Treatment

Brief Description of Services **Number of Beds (if applicable):**_____

_____
_____
_____
_____

Are you currently contracted by ADAD? ■ Yes ☐ No

Please provide address where all correspondence should be mailed:

Mailing Address	City	Zip Code	Island

Please list all applicable program locations:

Program Location Address	Island
Program Location Address	**Island**
Program Location Address	**Island**
Program Location Address	**Island**

Please provide the agency/organization's leadership information:

CEO / Executive Director or Equivalent	Phone #	Fax #	E-mail Address

Please provide point of contact information:

Point of Contact & Title	Phone #	Fax #	E-mail Address