



# **Mental Health Commission**

**Mental Health Act 2001 Section 64**

**Application for Registration as an Approved Centre**

## Guide to completing the Application

Please read these notes carefully **BEFORE** completing the application.

### General Information

- Please complete this application in **BLOCK CAPITALS** using a ballpoint pen in **BLACK INK**.
- Alternatively, a copy of this application is available in Microsoft Word and it is acceptable to complete the application electronically and submit by email. To obtain a copy of the application in Microsoft Word, please email [brian.osullivan@mhcirl.ie](mailto:brian.osullivan@mhcirl.ie).
- Where an application has been submitted by email, a hard copy of Section 6 of the application, with the original signature of the person applying to be the registered proprietor or the person with delegated responsibility for the running of the facility, must be submitted to the Commission.
- All sections of the application must be completed, as appropriate. Before any facility can be registered, the Mental Health Commission must be satisfied that the proposed service meets all the relevant requirements.
- Incomplete applications will be returned to the sender for completion and shall not be processed until such time as all the requested information is received by the Mental Health Commission. This will cause unnecessary delays in the registration process.
- It is an offence to knowingly provide false or misleading information [Section 64(8) (b) Mental Health Act 2001].
- Completed applications, including supporting documentation, should be returned:
  - By post, to Brian O’Sullivan, Standards & Quality Assurance Division, Mental Health Commission, St Martin’s House, Waterloo Road, Dublin 4 **or**
  - By email, to [brian.osullivan@mhcirl.ie](mailto:brian.osullivan@mhcirl.ie).

## Specific Information

**Section 1:** This section of the application asks for general details about the facility to which this application refers and must be completed in full, as appropriate.

**Section 2:** This section is only to be completed where the person applying to be the Registered Proprietor is the Health Service Executive and asks for information about the person with delegated responsibility for the running of the facility.

**Section 3:** This section is only to be completed where the person applying to be the Registered Proprietor is someone other than the Health Service Executive and asks for information about the person applying to be the Registered Proprietor and the organisation running the facility.

**Section 4:** This section asks for information about the service you provide or intend to provide.

**Section 5:** This section is only to be completed where the facility to which this application refers is not currently entered on the Register of Approved Centres. This section asks you to determine the facility's current or intended level of compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006.

**Section 6:** This section requires the person applying to be the Registered Proprietor, or the person with delegated responsibility for the running of the facility to make a declaration that the information he/she has provided is true and accurate before signing the application. A person who gives false or misleading information shall be guilty of an offence.

## Supporting Documentation required with Application for Registration

- **The following supporting documentation is required with all applications:**
  - Floor plan of facility. If a floor plan is not available, please enclose a description of the premise.
- **The following supporting documentation is also required where the person applying to be the Registered Proprietor is someone other than the Health Service Executive:**
  - Copy of photo-identification (i.e. passport or driver's licence)
  - Copy of Garda Síochána/Police Clearance obtained within the last three years, or the completed Mental Health Commission Garda Síochána/ Police Clearance Form
  - Copies of two most recent annuals reports, including audited accounts
  - Tax clearance certificate
  - Bank reference as to financial standing
  - Business plan for the facility
  - Details of cash flow for the facility.

## **Key Terms**

### **Act**

The “Act” means the Mental Health Act 2001.

### **Approved Centre**

A “centre” means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the Register of Approved Centres pursuant to the Act.

### **Person**

“Person” shall be read as importing a body corporate (whether a corporation aggregate or a corporation sole) and an unincorporated body of persons, as well as an individual, and the subsequent use of any pronoun in place of a further use of “person” shall be read accordingly.

### **Registered Proprietor**

The person whose name is entered on the Register as the person carrying on the centre.

### **The Register**

The Commission shall establish and maintain a register which shall be known as “the Register of Approved Centres” and is referred to in Section 64(1) of the Act as “the Register”.

**Section 1 General Information**

		For official use
<b>1.1 Facility Details</b>		
Name of the facility:		<input type="checkbox"/>
Address of the facility:		<input type="checkbox"/>
Main Telephone Number:	Main Fax Number:	<input type="checkbox"/> <input type="checkbox"/>
Date the facility was established (if applicable) <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)		<input type="checkbox"/>
If the facility was established at a different location, please state the date the facility located to the existing location/premises <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (dd/mm/yyyy)		<input type="checkbox"/>
Is the facility subject to an inquiry of any kind? (Please tick one) YES <input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/>
Is the facility currently entered on the Register of Approved Centres maintained by the Mental Health Commission? YES <input type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/>
<b>If Yes, please supply the name of the Approved Centre as entered on the Register, the date of registration and the reason for this application:</b>		
Name (if different to above):		<input type="checkbox"/>
Date of registration:		<input type="checkbox"/>
Reason for application: <input type="checkbox"/> Expiration of current registration period <input type="checkbox"/> Change of location <input type="checkbox"/> Other.		<input type="checkbox"/>
If Other, please specify: _____ _____ _____		

**Section 2 Only to be completed where the person applying to be the Registered Proprietor is the Health Service Executive**

**2.1 Information about the person with delegated responsibility for the running of the facility, e.g. the local health manager**

		For official use
Name of Proprietor: <b>Health Service Executive</b>		<input type="checkbox"/>
Name of Person with delegated responsibility:		<input type="checkbox"/>
Position of Person with delegated responsibility:		<input type="checkbox"/>
Address of Person with delegated responsibility:		<input type="checkbox"/>
Telephone Number:	Fax Number:	<input type="checkbox"/> <input type="checkbox"/>
Email Address:		<input type="checkbox"/>

This page applies to Health Service Executive (HSE) applications

**Section 3 Only to be completed where the person applying to be the Registered Proprietor is someone other than the Health Service Executive**

3.1 Information about the person applying to be the Registered Proprietor		For official use
Name of Proprietor:		<input type="checkbox"/>
*Name of Person with delegated responsibility (If different to Proprietor)		<input type="checkbox"/>
Position:		<input type="checkbox"/>
Address (if different to address given in Section 1.1):		<input type="checkbox"/>
Telephone Number:	Fax Number:	<input type="checkbox"/> <input type="checkbox"/>
Email Address:		<input type="checkbox"/>

**\*Where the Proprietor is an organisation, please provide details of the person with delegated responsibility for the running of the facility, e.g. chief executive officer.**

This page applies to non-HSE applications



**3.3 Organisation Detail (e.g. Independent sector, charitable institution, voluntary institution).**

		For official use
Name of organisation (if different to Section 1.1):		<input type="checkbox"/>
Address of organisation (if different to Section 1.1):		<input type="checkbox"/>
Is the organisation a charity or a company (please tick one):		<input type="checkbox"/>
Charity <input type="checkbox"/> Company <input type="checkbox"/>		
<b>If the organisation is a charity, please supply the Charity number:</b>		
Charity number:		<input type="checkbox"/>
<b>If the organisation is a company, please provide names of company directors and company registration number:</b>		
Names of company directors :		<input type="checkbox"/>
Company Registration number:		<input type="checkbox"/>
<b>If the organisation is a subsidiary of a holding company, please provide name and address of registered or main office of the holding company and the names of the directors of the holding company:</b>		
Holding company name:		<input type="checkbox"/>
Names of holding company directors :		<input type="checkbox"/>
Holding company address:		<input type="checkbox"/>
<b>Please give details of scale of charges payable by service users:</b>		
		<input type="checkbox"/>

<p><b>Please enclose:</b></p> <ul style="list-style-type: none"> <li>• a bank reference as to financial standing, including a statement of your ability to ensure the financial viability of the facility and a statement of whether you have ever been bankrupt or sequestration of estates ordered; and</li> <li>• a business plan for the facility; and</li> <li>• details of cash flow for the facility or last accounts.</li> </ul>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><b>Where the applicant is an organisation or subsidiary of a holding company, please enclose copies of at least the two most recent annual reports including audited accounts and a copy of current tax clearance certificate</b></p>	<input type="checkbox"/>

This page applies to non-HSE applications

**Section 4 Information about the Service you provide or intend to provide**

**4.1 Information about the Service**

		For official use
Does the facility provide care <u>and</u> treatment to persons suffering from mental illness <u>or</u> mental disorder?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
Number of patients <sup>1</sup> who can be accommodated in the facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
Number of residents <sup>2</sup> who can be accommodated in the facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
Function(s) of facility (tick all that apply):	<input type="checkbox"/> Acute mental health care <input type="checkbox"/> Mental health rehabilitation <input type="checkbox"/> Continuing mental health care/ long stay <input type="checkbox"/> Other	<input type="checkbox"/>
<b>If you have ticked “Other”, please give more information about the function(s) of the facility:</b>		
		<input type="checkbox"/>
		<input type="checkbox"/>
Service(s) provided by facility (tick all that apply):	<input type="checkbox"/> Adult mental health care <input type="checkbox"/> Forensic mental health care <input type="checkbox"/> Psychiatry of Later Life <input type="checkbox"/> Child & adolescent mental health care <input type="checkbox"/> Mental health care for people with intellectual disability <input type="checkbox"/> Other	<input type="checkbox"/>
<b>If you have ticked “Other”, please give more information about the function(s) of the facility:</b>		
		<input type="checkbox"/>
		<input type="checkbox"/>

<sup>1</sup> Patient under the Act refers to a person to whom an admission or renewal order relates, that is a person who is involuntarily admitted pursuant to Section 14

<sup>2</sup> Resident refers to a person receiving care and treatment in a centre



**4.2 Staffing****4.2.1 Clinical Staff**

	For official use
Name of Clinical Director:	<input type="checkbox"/>
Medical Council Registration Number of Clinical Director:	<input type="checkbox"/>
Name of Director of Nursing:	<input type="checkbox"/>
Total number of (WTE) <sup>3</sup> employed by the facility:	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Consultant Psychiatrists:	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Registered Medical Practitioners: (excluding Consultant Psychiatrists, insert Grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Nursing Staff: (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Occupational Therapists: (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Clinical Psychologists: (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Social Workers (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Care Officers (Central Mental Hospital only): (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> other clinical staff: (please specify)	<input type="checkbox"/>

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<sup>3</sup> WTE refers to Whole Time Equivalents

**4.2.2 Non Clinical Services**

	For official use
Number of (WTE) <sup>3</sup> Managers of facility: (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> Administrative Staff: (include grade details)	<input type="checkbox"/>
Number of (WTE) <sup>3</sup> other non-clinical staff: (please specify)	<input type="checkbox"/>

4.3 Description of Premises	For official use
Please provide a floor plan of the facility. If a floor plan cannot be provided, please provide a description of the premise on a separate sheet (e.g. square footage, day areas, bedrooms, bathrooms, sitting rooms, kitchens, clinical rooms, consultation rooms and therapy rooms).	<input type="checkbox"/>
Please state below whether the facility was purpose built or has been converted for use as a mental health service.	
	<input type="checkbox"/>
If the facility is not currently entered on the Register of Approved Centres, please provide an engineer's report stating how the premises is in compliance with Article 22 (Premises) of S.I. No 551 of 2006 Mental Health Act 2001 (Approved Centres) Regulations 2006	<input type="checkbox"/>

If the facility is not suitable for use as a mental health service on the date the application is made, details of planning permission, works or conversions are needed. Please attach project plan with timescales.	
	<input type="checkbox"/>

Does the building meet the requirements the Disability Act 2005 in terms of access?	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
If No, please state what arrangements are being put in place to meet the requirements of the Disability Act 2005. Please attach plan with timescales.		
	<input type="checkbox"/>	

## Section 5 Compliance with Regulations

- This section is only to be completed where the facility to which the application refers is not currently on the Register of Approved Centres.
- Please complete this section on compliance with the regulations. You will need to have a copy of the Mental Health Act 2001 (Approved Centres) Regulations 2006, S.I. No. 551 of 2006, in front of you to complete this section. For each subsection of a regulation, please answer “yes” or “no” in respect of whether you determine you comply or not in full with that subsection. Where a regulation has no subsections, please answer “yes” or “no” in respect of whether you determine you comply or not in full with that regulation.
- If you answer “yes” on the form in respect of a subsection of a regulation, it denotes that you determine you are in full compliance with that subsection. It means you can clearly provide evidence of compliance with that subsection. Details should be given of how exactly you meet the criteria specified under that subsection of the regulation.
- If you answer “no” on the form in respect of a subsection of a regulation, it means that you determine you do not comply with the criteria specified under that subsection.
- Where you answer “no” to compliance with a subsection of a regulation, please outline clearly how you intend to comply with the subsection in full by detailing all action(s) required and planned to achieve full compliance. Please provide projected timeframes for completion of such actions.



**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
6.	Food Safety	1)(a)  (1)(b)  (1)(c)  (2)(a)  (2)(b)  (2)(c)					<input type="checkbox"/>
7.	Clothing	(1)          (2)					<input type="checkbox"/>

**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
8.	Residents' Personal Property & Possessions	(1) (2) (3) (4) (5) (6)					<input type="checkbox"/>
9.	Recreational Activities						<input type="checkbox"/>

**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
10.	Religion						<input type="checkbox"/>
11.	Visits	(1)  (2)  (3)  (4)  (5)  (6)					<input type="checkbox"/>

**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
12.	Communication	(1)  (2)  (3)  (4)					<input type="checkbox"/>
13.	Searches	(1) (2) (3) (4) (5) (6) (7) (8) (9) (10)					<input type="checkbox"/>

**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
14.	Care of the Dying	(1)  (2)(a) (2)(b) (2)(c) (2)(d)  (3)(a) (3)(b) (3)(c)  (4)  (5)					<input type="checkbox"/>
15.	Individual Care Plan						<input type="checkbox"/>





**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
20.	Provision of Information to Residents	(1)(a) (1)(b) (1)(c) (1)(d) (1)(e) (2)					<input type="checkbox"/>
21.	Privacy						<input type="checkbox"/>





**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
26.	Staffing	(1)  (2)  (3)  (4)  (5)  (6)					<input type="checkbox"/>
27.	Maintenance of Records	(1)  (2)  (3)  (4)					<input type="checkbox"/>





**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
32.	Risk Management Procedures	(1) (2)(a) (2)(b) (2)(c) (2)(d) (2)(e) (2)(f) (3)					<input type="checkbox"/>
33.	Insurance						<input type="checkbox"/>

**Section 5**

**Compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006**

Reg	Area	Sub-Section	Yes/ No	If Yes, how do you demonstrate compliance	If No, please state action(s) planned to achieve full compliance	Timeframe for Completion	MHC Use only
34.	Certificate of Registration						<input type="checkbox"/>

**Section 6                      Declarations**

**To be completed by the person applying to be the Registered Proprietor or the person with delegated responsibility for the running of the facility as stated in Section 2.1 or in Section 3.1**

Has the person applying to be the Registered Proprietor ever:	YES	NO	For official use
(i) been convicted of a criminal offence, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) been convicted of an offence under Part 5 of the Mental Health Act, 2001, or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) failed or refused to furnish the Commission with information pursuant to Section 64(8) or furnished the Commission with information that is false or misleading in a material particular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) not more than one year before the registration or removal from the register, contravened a condition under Section 64 (6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The information provided in this application is true and accurate to the best of my knowledge and belief.

I understand that if I make any false or misleading statement it may be retained and used in evidence in a prosecution for carrying on or managing an approved centre (under false pretence) or in any subsequent legal proceedings.

	For official use
Signed:	<input type="checkbox"/>
Date:	<input type="checkbox"/>
Position/Job Title:	<input type="checkbox"/>
Company seal	<input type="checkbox"/>

***Please review the Supporting Documentation Checklist on the next page before submitting your completed application.***

## Supporting Documentation Checklist

Have you Enclosed?	Please tick <input type="checkbox"/>	For official use
<b>Documentation required with all applications</b>		
Floor plan of facility. If a floor plan is not available, please enclose a description of the premises		<input type="checkbox"/>
If the facility is not currently entered on the Register: Engineer's report stating how compliance with Article 22 of S.I. No 551 of 2006 Mental Health Act 2001 (Approved Centres) Regulations 2006 is achieved.		<input type="checkbox"/>
<b>Documentation required where the person applying to be the Registered Proprietor is someone other than the Health Service Executive</b>		
Copy of passport or driver's licence of the proprietor or the applicant		<input type="checkbox"/>
Copy of Garda Síochana / Police Clearance obtained within the past 3 years, or the completed Garda Síochana/Police Clearance Form		<input type="checkbox"/>
Copies of 2 most recent annual reports, including audited accounts (where applicable)		<input type="checkbox"/>
Tax clearance Certificate (where applicable)		<input type="checkbox"/>
Bank Reference as to financial standing		<input type="checkbox"/>
Business plan for the facility		<input type="checkbox"/>
Details of cash flow for the facility		<input type="checkbox"/>