Orientation Number: _____

☐ New Provider
☐ Expanded Service/Existing Provider
☐ New Service/Existing Provider

Alabama Department of Mental Health
CERTIFICATION APPLICATION
FOR COMMUNITY PROGRAMS PROVIDING MENTAL HEALTH A
DEVELOPMENTAL DISABILITIES AND/OR SUBSTANCE ABUSE SERVICES

Applying for Designated Mental Health Facility (DMHF): Yes ☐ No ☐ If yes, please check all that apply:
Non-Hospital Outpatient Commitment ☐ Non-Hospital Inpatient Commitment ☐
OR
Currently certified as DMHF: Yes ☐ No ☐

I. APPLICANT

_____
NAME OF AGENCY

_____
STREET ADDRESS/PO BOX

_____
CITY STATE ZIP CODE

_____
TELEPHONE & FAX

_____
NAME OF EXECUTIVE DIRECTOR

TYPE OF OWNERSHIP:

Non-Profit _____ Profit _____ Public _____

STATUS OF OWNERSHIP:
Corporation _____ Partnership _____

Board President's Mailing Address and/or Email Address and Names/Titles of Officers:

_____
_____
_____
_____
_____

II. SUBAPPLICANT (If Applicable)

_____
NAME

_____
STREET ADDRESS/PO BOX

_____
CITY COUNTY

_____
ZIP CODE

_____
TELEPHONE & FAX

_____

_____
NAME OF EXECUTIVE DIRECTOR:

TYPE OF OWNERSHIP:

Non-Profit _____ Profit _____ Public _____

STATUS OF OWNERSHIP:

Individual _____ Corporation ____ Partnership

Names/Titles of Officers:

_____
_____
_____
_____
_____

III. FACILITY

Specify Name of Facility to be on the Certificate

ghjghj

STREET ADDRESS

CITY COUNTY

gj

ZIP CODE

TELEPHONE & FAX

CONTACT PERSON

Executive Director Email:

Classification of Facility: MH ___ DD___ SA ___

Type of Facility/Service: _____

_____

(e.g. Residential, Day, Outpatient, etc.)

Number of Beds: Certified: _____ Total Beds: _____

OR: _____

Total Occupancy Requested: _____

Application for: New Site_____ Replacement Site _____

(Replacement Site of What?) _____

Bed/Occupancy Increase From # ____ to # _____

Projected Occupancy Date: _____

New Executive Director___

Program Director____

Clinical Director___

IV. I hereby certify that all statements made in this application are true and correct to the best of my knowledge. Also, I agree to operate said facility in accordance with the Rules and regulations promulgated by the law(s) governing the operation and maintenance of the type of facility for which this application is made.
Authorized Signature:

_____

Agency:

_____

Address: _____

_____

_____

Disclaimer:
Programmatic certification and/or life safety (physical facility) certification does not imply that the Department of Mental Health will contract with your program.

Will home be occupied by persons who require ADA accommodations? Yes _____ No _____

If yes, what type?

_____

_____

FOR DMH USE ONLY

V. APPROVAL OF APPLICATION: (Division)
Authorized Signature: _____
Title: _____
Date: _____

V. MAIL APPLICATION TO:
DMH Office of Certification Administration
100 N. Union Street, Suite 540
P.O. Box 301410
Montgomery, AL 36130-1410

Submit