Orientation Number: ______________

Alabama Department of Mental Health

***CERTIFICATION APPLICATION***

FOR COMMUNITY PROGRAMS PROVIDING MENTAL HEALTH AND/OR DEVELOPMENTAL DISABILITIES AND/OR SUBSTANCE ABUSE SERVICES

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

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

STREET ADDRESS/PO BOX

CITY ZIP CODE

TELEPHONE & FAX

NAME OF EXECUTIVE DIRECTOR

TYPE OF OWNERSHIP:
Non-Profit ______ Profit ______ Public ______

STATUS OF OWNERSHIP:
Corporation ______ Partnership ______ ______
Other: (specify) ______
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 ______
Other: (specify) ______
Names/Titles of Officers: ______

III. FACILITY

Specify Name of Facility to be on the Certificate

STREET ADDRESS

CITY COUNTY 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 (circle): 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: ______

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: ______

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

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

## INFORMATION FOR COMPLETING APPLICATION

Designated Mental Health Facility (580-2-9-.19): CHECK APPLICABLE BOX(ES)

I. APPLICANT/CONTRACTOR:

(1) Name of operating organization (Corporation, etc.)
(2) Street Address of operating organization, to include post office box as applicable
(3) City and State location for operating organization, to include zip code
(4) Telephone and fax number (including area code)
(5) Name of the Executive Director within the operating organization
(6) Type of Ownership: Check one block
(7) Status of Ownership: Check one block
(8) List the corporations Officers and their mailing address

II. SUBCONTRACTOR INFORMATION (if applicable):

(1) Name of subcontractor organization (Corporation, Individual, etc.)
(2) Street Address of subcontractor organization
(3) City and State location of subcontractor, to include zip code
(4) Telephone and number (including area code)
(5) Name of Executive Director for the subcontractor
(6) Type of Ownership of subcontractor: Check one block
(7) Status of Ownership: Check one block
(8) List the corporations Officers and their mailing address

III. FACILITY:

(1) Specify the full name of the facility that is to be certified. All correspondence and documentation will utilize this name.
(2) Actual street address of the facility
(3) City and County location of the facility, to include zip code
(4) Telephone and fax number (including area code)
(5) Name of contact person at this facility/site
(6) Classification of Facility: MH-Mental Health/Mental Illness
DD –Developmental Disabilities SA-Substance Abuse
(7) Type of Facility: Utilize designations by DMH for facility/service types
(8) Number of Beds: Indicate actual number of beds to be certified (if applicable);
(9) Total Occupancy Requested: Indicate total number of beds in the facility; OR Total Occupancy of the Program (e.g. day habilitation/rehabilitation)
(10) Indicate whether this is a new site, replacement site, increase in beds/occupancy, etc.
(11) Indicate the projected date of occupancy or beginning of the program.
(12) Check appropriate block if home will be occupied by persons who require ADA accommodation and if yes explain what type.

IV. Signature and address of the executive director or authorized agency for the applicant.

V. Facilities Certification Office will forward a copy of the application, and the original supporting documents, to the applicable, respective division for approval to proceed with the certification process.

VI. Applicant will forward the completed application and required supporting documents to the DMH Office of Certification Administration.