Date

Name

Executive Director

Provider Agency Name

Provider Address

City, State Zip

Dear Executive Director:

I am pleased to inform you that your request for certification of your Mental Illness Provider Agency Name Services located at Provider Address in City as a replacement site for your Mental Illness Provider Agency Name Adult and Adolescent Outpatient Services located at Provider Address in City has been approved. Enclosed please find the certificates of compliance that must be posted in the respective facilities at all times and are not transferable to any other locations or entities.

Please return the certificates for Mental Illness Provider Agency Name Services located at Provider Address in City to the Office of Certification Administration within ten (10) days of receipt of this letter. Should you have any questions please contact the Office of Certification Administration at 334-353-XXX.

 Sincerely,

 Commissioner’s Full Name

 Commissioner

 (Commissioner’s initials/OCA staff)

cc: (Service Division Associate Commissioner)

 (Copied Contact)