Date

Name

Executive Director

Provider Agency Name

Provider Address

City, State Zip

**Temporary Operating Authority For**

**Provider Agency Name**

**Provider Address**

**City, State Zip**

Service Type (Service Division-ID, MH, or SA), One (1) Resident (Number Served)

Dear Executive Director:

Based on the representations made by you in your application for certification and the recommendation of the Associate Commissioner for the Division of Developmental Disabilities Services, I hereby issue your agency Temporary Operating Authority (TOA) for Provider Agency Name to provide service type for qualified persons with intellectual disabilities at Provider Agency Full Address (city, state). This TOA is effective immediately and will expire on Date.

Prior to the expiration of your TOA, this site will undergo a site certification review. Should this review indicate that this program does not sufficiently comply with applicable departmental standards, the program will not be certified to operate, and upon notice from this department, may be ordered to cease all ongoing operations.

Should you have any questions concerning this matter, please contact the Office of Certification Administration at 334-353-XXXX.

 Sincerely,

 Commissioner’s Full Name

 Commissioner

 (Commissioner’s initials/OCA staff)

cc: (Service Division Associate Commissioner)

 (Copied Contact)