

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

Orientation Number: \_\_\_\_\_

- |                          |                                    |
|--------------------------|------------------------------------|
| <input type="checkbox"/> | New Provider                       |
| <input type="checkbox"/> | Expanded Service/Existing Provider |
| <input type="checkbox"/> | New Service/Existing Provider      |

Applying for Designated Mental Health Facility (DMHF)/Setting: Yes  No  If yes, please check all that apply:

Non-Hospital Outpatient Commitment  Non-Hospital Inpatient Commitment

OR

Currently Certified as DMH/Setting: 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:**  
 Individual \_\_\_\_\_ 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/SETTING**

Specify Name of Facility/Setting to be on the Certificate  
 \_\_\_\_\_  
 STREET ADDRESS  
 \_\_\_\_\_  
 CITY COUNTY  
 \_\_\_\_\_  
 ZIP CODE  
 \_\_\_\_\_  
 TELEPHONE & FAX  
 \_\_\_\_\_  
 CONTACT PERSON  
 \_\_\_\_\_  
 Executive Director's Email

**Classification of Facility/Setting:**  
 MH \_\_\_\_\_ DD \_\_\_\_\_ SA \_\_\_\_\_  
**Type of Facility/Service/Setting:**  
 \_\_\_\_\_  
 (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 Address?) \_\_\_\_\_  
 Bed/Occupancy Increase From # \_\_\_\_\_ to # \_\_\_\_\_

Projected Occupancy Date: \_\_\_\_\_

New Executive Director \_\_\_\_\_

Clinical Director \_\_\_\_\_

IV. I hereby certify that all statements made in this application are true and correct to the best of my knowledge. I understand that untruthful/fraudulent information may be cause for denial of my application. No future applications will be considered. Also, I agree to operate said facility/setting in accordance with the Rules and regulations promulgated by the law(s) governing the operation and maintenance of the type of facility/setting for which this application is made.

Executive Director Signature and Date:

\_\_\_\_\_

Agency:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

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

Will the 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: \_\_\_\_\_

**MAIL APPLICATION TO:**

**DMH Office of Certification Administration**

**100 N. Union Street, Suite 540**

**P.O. Box 301410**

**Montgomery, Alabama 36130-1410**