Orientation Number: ____________________

- New Provider
- Expanded Service/Existing Provider
- New Service/Existing Provider
- Non-Waiver Provider

Alabama Department of Mental Health

CERTIFICATION APPLICATION

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

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 OWERSHIP:
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

____
ZIP CODE COUNTY

____
TELEPHONE FAX

____
NAME OF EXECUTIVE DIRECTOR

TYPE OF OWERSHIP
Non-Profit Profit Public

STATUE 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

____
ZIP CODE COUNTY

____
TELEPHONE FAX

____
CONTACT PERSON

____
Executive Director's Email

Classification of Facility/Setting:
MH DD SA CWP _____

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 # ________

Bed/Occupancy Decrease From # _______ to # ________

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:

____

____

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

Projected Occupancy Date: ________________________

New Executive Director ______

Clinical Director ______

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