Orientation Number: _____

___ New Provider
___ Expanded Service/Existing Provider
___ New Service/Existing Provider
___ Waiver 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 # _____

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