



Division of Certification

Program Modification Application

Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to make changes to existing certified programs within the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

A. **DMH Certified Provider:** _____

Date of Application: _____

DMH Certification Designation(s) Currently Held:

DMH/D___ DMH/H___ DMH/C___ DMH/O___ DMH/G___ DMH/P___

B. **Provider Contact Information:** Please include a single contact person responsible for this application. A primary place of business, primary and secondary telephone numbers, and valid email address must be included. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All correspondence will be conducted with the indicated contact person or the provider's Executive Director.

Contact Person: _____ **Position** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (if not same): _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone Number (primary) _____ **(secondary)** _____

Email Address _____ **Fax Number** _____

C. **Assurances and Signatures:** As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the state of Mississippi (documentation attached). I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services

Executive Director Signature _____ **Date** _____



Application to Modify Existing Program Certification

Change in Physical Location

Current Certified Program to be Modified

Current Program Certificate #

Physical Address of New Location

List all DMH – certified services to be provided at the locations

(attach additional pages if needed)

Is The New Location Currently Certified by DMH? Yes _____ If yes, Provide Certificate Number _____
 No _____

Was the New Location Previously Certified by DMH? If so, provide date(s) _____

Are any non-DMH certified services provided at this physical location? Yes No

Nature/description of the non-DMH – certified services

Requested Capacity

Proposed Change Date

Required Attachments: _____ **Floor Plan for New Program (including dimensions and usable space with service areas clearly identified)** _____ **designated**
 _____ **Site Specific Permits, Licenses, Inspection Reports or other**
 _____ **Proof of Operable Utilities**
 _____ **(For Supervised Living) Evidence of furnishings as required in Rule 34.1**

Other Documentation Included for Review:

Change the Name of Program

Current Certified Program to be Modified

Current Program Certificate #

New Name of Program

Change Capacity of Program

Current Certified Program to be Modified

Current Program Certificate #

Current Capacity

Requested Capacity

Reason for Change

Required Attachments: _____ Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified)

Other Documentation Included for Review:

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