Division of Certification

Service Modification Application

Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to make changes to existing certified services 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. <u>Provider Contact Information:</u> 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. <u>Assurances and Signatures:</u> 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 Service Certification

Service Specific Information

Certified Service to be Modified	
Changes to Certified Service	
Reason for Requested Change	
Proposed Start Date	

Required Attachments:

_____ **Policies and Procedures for Certified Service(s)**

_____ **Staffing Plan, including Staff qualifications and/or credentials**

_____ **Job Descriptions for Staff providing the Certified Service(s)**

_____ **Position Specific Staff Training Plan**

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