Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

Division of Certification

New Program Application Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to add 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. The DMH certified application review process will begin 30 days from the receipt date of the application.

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** ☐ **DMH/I** ☐

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**_____

Mississippi Department of Mental Health *Supporting a Better Tomorrow...One Person at a Time*	**Application to Add a New Program** ***Provider must already be certified for the Service**

Program – Specific Information	
Name of Program to be Certified	
Physical Address of New Program	
Room Number (if applicable)	
Program Location **(Name of school or building if applicable)**	
Days/Hours New Program will be in Operation	
Proposed Start Date	
Requested Capacity based on usable physical space	
Target Population (For Day Treatment, **specify ages/age-range of individuals to be served)**	
List all DMH – certified services to be provided at the locations **(attach additional pages if needed)**	

Is This Location Currently Certified by DMH? **Yes**_____ **If yes, Provide Certificate Number**_____

No_____

Was the 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	
Geographic Area(s) to be Served (county, city, school districts) ***If School District, Must Specify District Wide or Specific School)**	

Required Attachments:

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

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

_____ **Job Descriptions for Staff providing the New Services**

_____ **Site Specific Permits, Licenses, Inspection Reports or other**

_____ **Proof of Operable Utilities**

_____ **(For Supervised Living) Evidence of Furnishings**

Other Documentation Included for Review:

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