Mississippi Department of Mental Health
Division of Certification
Interested Provider Application

INSTRUCTIONS: This application is utilized to apply to the DMH to initiate the process to become certified to provide services within the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance use disorders (SUD). Please read carefully and complete this form. All attachments should be submitted with the completed application. Please type or print legibly. This application must be completed by the individual or governing body with the authority and responsibility for developing policies, procedures, and business practices for which the agency and its services will be operated. This may include the executive director, chairperson of the governing authority, owner, etc. All dates should include the month, date, and year. Original signatures must be included. If additional space is needed to respond, please provide the information as attachments and reference the application section.

A. ***Entity Seeking Certification***: _____

B. ***Date of Application***: _____ **C.** ***Agency's Tax ID Number***: _____

D. ***Date Agency Attended Interested Provider Orientation***: _____

E. ***Names of Individuals Representing Agency at Interested Provider Orientation***: _____

_____

F. ***Contact Information***: **Please include a single contact person responsible for this application. Must include primary place of business, primary and secondary telephone numbers, and valid email address. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All DMH correspondence will be conducted with the indicated contact person.**

Contact Person: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same as street address): _____

City: _____ State: _____ Zip Code: _____

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

Email Address _____ Fax Number _____

G. ***Applicant Organizational Structure***: Identify type. Applicants must be registered entities to conduct business within the State of Mississippi. Documentation of incorporation, formation, or partnership authority from the MS Secretary of State's Office will be required in order to complete the application process.

Sole proprietorship ___ Non-profit corporation ___ For-Profit Corporation __ Partnership ____

Governmental Entity __ University _____ Other _____

Applicants must include an organizational chart that identifies agency leadership and delineates lines of authority. Applicants must include documentation of incorporation with the MS Secretary of State's office.

H. ***Applicant Governing Authority***: Identify the names and positions of all members of the applicant's governing authority/ advisory board. All non-profit and for profit agencies must provide evidence of a governing board of no less an 8 members. All sole-proprietorship agencies must provide evidence of an advisory board with no less than 8 members. Applicants that are governmental entities or universities do not have to include this information. Please include this information as an attachment with this section referenced.

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I. ***Applicant Leadership***: Identify the person(s) responsible for the daily management, oversight, and direction of the applicant entity. This may include the Proprietor (in the case of a sole proprietorship), Executive Director and the Chief Financial Officer or Business Manager.

Executive Director _____

Does this individual have a Master's Degree in a mental health or related field? _____yes __no

Years of related experience _____

Clinical Director _____

Does this individual have a license in a mental health or related field? _____yes ____no

License Number_____

Years of related experience _____

Chief Financial Officer/Business Manager _____

Years of related experience _____

Applicants must include resumes for key leadership positions.
Applicants must include evidence of professional licensure (if applicable) and signed Releases of Information Forms from all identified leadership positions in order for DMH to obtain an official transcript from the primary source to verify that educational requirements have been met.

J. ***Background***: Answer the following about the applicant leadership in Section I and member of the governing authority in Section H.

1. Has any member of the applicant leadership identified in Section I and/or any member of the governing authority identified in Section H ever been convicted for a felony offense against the law? _____Yes ____No

   If yes, please provide the name of the individual, type of conviction, date of conviction, place of conviction, and action taken.

   _____

   _____

2. Has any member of the applicant leadership in Section I and/or any member of the governing authority identified in Section H held licensure or certification from MS or another state to provide mental health, substance abuse, or intellectual/developmental disabilities services? ____ Yes ____ No

   If yes, please provide by individual, the type of licensure or certification, the licensing or certifying entity, and the valid dates of licensure or certification.

   _____

   _____

3. Is your agency a Mississippi Medicaid provider? _____ Yes _____ No

   If yes, please include your provider number _____

4. Is your agency a Medicare provider? _____ Yes _____ No

   If yes, please include your provider number _____

Applicants must include signed Releases of Information Forms from all identified leadership positions in order to complete background checks on agency leadership staff. Applicants must include evidence of current licensure and/ or certification from all other states/ entities in which the agency operates.

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K. ***Financial Resources***: Applicants must show the fiscal resources and fiscal management practices needed in order to operate and provide services.

All Applicants must submit a Proposed Budget.

Applicants in operation must provide Audited Financial Statements including an unqualified opinion from a CPA and 6 months of bank statements to document in reserve 3 months of operating expenses based on the proposed budget.

Applicants not currently in operation must provide Proforma Financial Statements compiled by a licensed CPA and evidence of planned resources in reserve of 3 months of operating expenses based on the proposed budget.

Applicants that cannot demonstrate financial viability will not be approved.

L. ***Services Applicant Seeks to Provide***: Indicate which services for which the applicant seeks to receive certification. Services must meet DMH definitions and DMH Operational Standards.

Adult Mental Health (SMI)

Outpatient Therapy* _____
Psychosocial Rehabilitation* _____
Senior Psychosocial Rehabilitation __
Crisis Response* __
Physician/Psychiatric* _____
Community Support* _____
Peer Support* _____
Supervised Living _____
Supported Living _____
Crisis Stabilization _____
PACT _____
Acute Partial Hospitalization__
Consultation and Education __
Supported Employment ___

Children/Youth (SED)

Outpatient Therapy* _____
Day Treatment* _____
Crisis Response* _____
Physician/Psychiatric* _____
Community Support* _____
Peer Support* _____
MAP Team* _____
Targeted Case Management* ___
Wraparound Facilitation_____
Intensive Outpatient _____
Respite _____
Prevention/Early Intervention ___
Therapeutic Group Home _____
Therapeutic Foster Care _____
Crisis Stabilization _____
Consultation and Education ___
Acute Partial Hospitalization___
Family Support and Education __

Substance Use Disorders (SUD)

Outpatient Therapy* ___
Intensive Outpatient: Adult___
Intensive Outpatient: Adolescent___
Prevention* _____
Primary Residential _____
Transitional Residential ___
DUI Assessment _____
Recovery Support ___
Withdrawal Management __
Opioid Treatment ___
Consultation & Education _
Partial Hospitalization ____
Crisis Response Services* __
Peer Support Services* ____

Intellectual/Developmental Disabilities (IDD)

ID/DD Waiver (1915c)

Supervised Living _____
Supported Living _____
Host Homes ___
Shared Supported Living___
Supported Employment
Job Discovery _____
Crisis Support____
Crisis Intervention ___
Home/Community Supports__
Community Respite ___
Behavior Support _____
In-Home Nursing Respite ____
In-Home Respite ___
Day Services-Adult____
Prevocational ___
Transition Assistance ___

IDD Community Support Program (1915i)

Day Habilitation ___
Prevocational ___
Supported Employment _____

Please Note: All services marked with an asterisk (*) are designated as Core Services. Any agency seeking certification to provide a Core Service must provide all Core Services for the identified target population. A full list of Core Services is available in Chapter 3 of the DMH Operational Standards.

M. ***Location of Services/Geographical Area to be Served***: Identify the proposed location of services and the geographical area to be served. Please be as specific as possible. For example, applicant will serve x, y, z counties with programs located in x county or applicant will be physically located in x county and will accept referrals statewide.

_____
_____
_____

N. ***Timelines and Policies/Procedures***: **Applicants must provide a copy of the agencies policies and procedures addressing Chapters 3 through 17 and any applicable Chapters 18-54 of the DMH Operational Standards. Applicants must provide a timeline for service delivery and implementation following certification for each service for which certification is being sought. Applicants must provide jobs descriptions for staff providing services, including staff qualifications and/or credentials.**

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O. ***Additional Information***: Please provide any additional information the applicant believes would be helpful in making a determination regarding this application. List items included.

_____

_____

_____

P. ***Certification of Application***: This certification is to be read, signed, and dated by the applicant. The individual signing must be the proprietor in the case of a sole proprietorship, the Executive Director or chair of the governing authority of a corporation, governmental entity, or individual identified and granted authority by the university.

I certify that this application and its attachments have been carefully completed and reviewed. To the best of my knowledge, the information contained in this application and its attachments is true, accurate and complete.

Signature	Date

Type or Print Name and Title of Individual Signing

Submit application and attachments to:

Mississippi Department of Mental Health, Division of Certification
239 North Lamar St. Suite 1101
Jackson, MS 39201
Telephone: 601-359-1288

Please carefully review the Application and the required attachments outlined in The Application Checklist before submission. All components of the application packet must be submitted at a single time to the Division of Certification. Incomplete applications will not be processed.

****Please Note: Applications are accepted only in January and July****