Reset Form

APPLICATION FOR CERTIFICATION AS AN ADDICTION TREATMENT SERVICES PROVIDER

State Form 55376 (R4 / 3-16)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION
CERTIFICATION AND LICENSURE
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739

INSTRUCTIONS: *1. Complete original application and attachments.*
2. Forward to address in upper right corner of form.

I. GENERAL INFORMATION

Select type of provider. ☐ Addiction Treatment Services Provider (Outpatient) ☐ Addiction Treatment Services Provider (Regular) ☐ Opioid Treatment Facility / Opioid Treatment Program

Type of application ☐ New application ☐ Renewal

Legal name of applicant agency *(As on file with the Indiana Secretary of State's Office, if applicable)*

Doing Business As (DBA) name of agency, if different

Employer identification number *(if applicable)*

Type of organization *(check one)* ☐ Governmental Entity ☐ Nonprofit ☐ For Profit

Name of chief executive officer / owner of agency

Address of applicant agency – main business office location *(A post office box number is not considered a location.) (number and street)*

Mailing address of applicant agency *(If different from location address)*

City, state, and ZIP code

County

Telephone number ( )

Fax number ( )

E-mail address of chief executive officer / owner

II. SITE(S) OF ADDICTION TREATMENT SERVICE

Name of facility

Physical address of facility *(number and street)*

City, state, and ZIP code

County

Telephone number ( )

Fax number ( )

Date of last fire / safety inspection *(month, day, year)*

Result: ☐ Without violation ☐ With violation *(Attach Plan of Correction.)*

Array of Services Per Rule: *Applicants must indicate all services provided at this location. (Check all that apply.)*
☐ Outpatient Treatment Services ☐ Intensive Outpatient Services ☐ Detoxification Services

Populations served
☐ Seventeen (17) and under ☐ Eighteen (18) and over

Agency has specialized programs for the following populations:
☐ Women ☐ Pregnant Women ☐ Veterans

II. SITE(S) OF ADDICTION TREATMENT SERVICE *(continued) (Add additional sheets if necessary.)*

Name of facility

Physical address of facility *(number and street)*

City, state, and ZIP code | County

Telephone number ( ) | Fax number ( )

Date of last fire / safety inspection *(month, day, year)*

Result:
☐ Without violation ☐ With violation *(Attach Plan of Correction.)*

Array of Services Per Rule: *Applicants must indicate all services provided at this location. (Check all that apply.)*
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III. RESIDENTIAL SITES (*See requirements below.**)

**In order to provide residential services, you need to be certified by DMHA as a Residential Care Provider or an Addiction Treatment Services Provider (Regular).*

Name of facility

Physical address of facility *(number and street)*

City, state, and ZIP code | County

Telephone number ( ) | Fax number ( ) | Number of beds

Date of last fire / safety inspection *(month, day, year)*

Result:
☐ Without violation ☐ With violation *(Attach Plan of Correction.)*

Type of residential setting
☐ SUB – Subacute Stabilization Facility ☐ SGL – Supervised Group Living Facility ☐ TRS – Transitional Residential Facility

Populations served
☐ Seventeen (17) and under ☐ Eighteen (18) and over

Agency has specialized programs for the following populations:
☐ Women ☐ Pregnant Women ☐ Veterans

Name of facility

Physical address of facility *(number and street)*

City, state, and ZIP code | County

Telephone number ( ) | Fax number ( ) | Number of beds

Date of last fire / safety inspection *(month, day, year)*

Result:
☐ Without violation ☐ With violation *(Attach Plan of Correction.)*

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IV. MISSION STATEMENT
Please insert the agency mission statement.

V. GENERAL CONDITIONS	
Upon certification for the requested services(s), the applicant shall abide by all laws, rules and administrative directive governing the certified service(s). Please refer to Article 4.4- Addiction Treatment Services Provider Certification, 42 CFR Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records, Article 27 – Human Services, and Article 39 – Health Records, Article 7.5 – Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions, and Article 6 – Residential Care Providers Certification as applicable. The applicant affirms that the statements and declarations contained herein are true and correct to the best of the applicant's knowledge.	
Signature of chief executive officer / owner of applicant agency	Date *(month, day, year)*