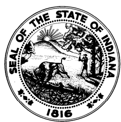

# APPLICATION FOR CERTIFICATION AS AN ADDICTION TREATMENT SERVICES PROVIDER

State Form 55376 (R6 / 2-17)

**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.)*
☐ 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

## 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.)*

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

| 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.<br><br>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)* |