Reset Form

AGENCY APPLICATION

State Form 55944 (R5 / 8-19)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

AGENCY INFORMATION		
Name of organization (*As Registered with Indiana Secretary of State)*		
Organization Employer Identification Number (EIN)		National Provider Identification Number (NPI)
Application Contact		E-mail address
Street address of agency location		City, state and ZIP code
Telephone number ( )	Fax number ( )	Main E-mail address
MAILING ADDRESS OF ADMINISTRATION BILLING OFFICE		
Street address		City, state and ZIP code
Main telephone number ( )	Fax number ( )	Website (*if available*)
County(ies) of service		
List types of insurance accepted by the agency (i.e. Medicaid, Health Indiana Plan (HIP), self-pay, etc.).		

SERVICES	***Mark with an X if your agency is providing the service; if your agency is not providing the service, please indicate a local agency that could render the service.***
Alcohol and Other Drug Screening	
Case Management	
Comprehensive Mental Health and Substance Use Disorder Assessment	
Health Care Coordination Services	
Intensive Outpatient Treatment	
Medication Assisted Treatment (OTP Treatment Bundles)	
Medication for Treatment of Mental Health and/or Substance Use Disorders	
Medication Training & Support	
Mental Health Counseling (Individual, Family, or Group)	
Peer Recovery Support Services	
Psychiatric Evaluation and/or Medication Review	
Recovery Residence – Room Only	
Recovery Residence – Room and Board	
Reentry Services	
Residential – Low Intensity	
Residential – High Intensity	
Skills Training and Development (Individual, Group)	
Substance Use Disorder Counseling (Individual, Family, Group)	
Supported Employment Services	
Telepsychiatry	
Transportation	

PROVIDER INFORMATION		
PROVIDER NAME *(FIRST, LAST)*	**DEGREE AND/OR LICENSURE**	**Would you Qualify to be a: OBHP / QBHP**
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP
		OBHP / QBHP

(If you have additional providers, please attach their information to the application in an Excel workbook.)

By signing below, your agency agrees that your providers will attend all mandatory Recovery Works trainings prior to providing services. Additionally, your agency will only claim for services marked with an "X" on page 1.

Signature	Date *(month, day, year)*
Printed name	
Title	

CERTIFICATION – *FOR DMHA USE ONLY*		
Date *(month, day, year)*	Return to Recovery Works *(month, day, year)*	
Certification reference number	Type of certification	Expiration date of certification *(month, day, year)*
Notes		