Reset Form

AGENCY APPLICATION - ADDITIONAL PROVIDERS

State Form 55939 (11-15)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

AGENCY INFORMATION	
ORGANIZATION NAME (*As Registered with Indiana Secretary of State)*	
APPLICATION CONTACT	E-MAIL
MAILING ADDRESS OF ADMINISTRATION BILLING OFFICE	
STREET	CITY, STATE, AND ZIP CODE
MAIN TELEPHONE NUMBER ( )	FAX NUMBER ( )

PROVIDER INFORMATION			
PROVIDER NAME *(FIRST, LAST)*	**DEGREE AND/OR LICENSURE**	**Would you Qualify to be a: OBHP / QBHP**	**WILL YOU NEED WITS ACCESS? Y/N**
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N
		OBHP / QBHP	Y / N

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

By signing below, your agency agrees that your providers will attend all mandatory Recovery Works trainings no later than June 30, 2016.

PRINTED NAME _____

SIGNATURE _____ DATE *(month, day, year)* _____

TITLE _____