RECOVERY WORKS APPLICATION

State Form 56415 (R6 / 6-24)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION

Recovery Works
INDIANA'S FORENSIC TREATMENT PROGRAM

AGENCY INFORMATION		
Name of organization (Must match DMHA certification)		Organization Employer Identification Number (EIN)
Main Application Contact		Main E-mail address
Address of main/office location		City, State, and ZIP code
Telephone number ( )	Fax number ( )	Company Website (if applicable)

Physical Location Address(es) *(number and street, city, state, and ZIP code)*	City	County

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

DMHA APPROVED SERVICES	*Mark with an X if your agency is providing the service.*
Recovery Residence – Room Only	
Recovery Residence – Room and Board	
Recovery Residence – Level II____ Level III____ Level IV____	
Residential – Low Intensity 3.1	
Residential – High Intensity 3.5	
Outpatient Services (Substance use and/or Mental Health)	
Substance Use Services	
Mental Health Services	
Intensive Outpatient Treatment—IOT	
Recovery Community Organization (RCO)	

LICENSED STAFF ONLY **Recovery Residence II and III skip section		
PROVIDER NAME *(FIRST, LAST)*	**LICENSURE**	**Certification/License Expiration**

(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 training 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	

FOR DMHA USE ONLY (Do NOT write below)		
Date *(month, day, year)*	Return to Recovery Works *(month, day, year)*	
Application Reference Number	Type of certification	Expiration date of certification *(month, day, year)*
Notes		