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| SEAL31.TIF | **APPLICATION COVER SHEET**  State Form 56583 (R3 / 10-21) | FAMILY AND SOCIAL SERVICES ADMINISTRATION  DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)  YOUTH HOME AND COMMUNITY-BASED WRAPAROUND SERVICES (HCBS)  402 W. Washington Street, Room W353  Indianapolis, In 46204-2739  Telephone: (317) 232-7800 |

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| **Contact Information for person completing the application** | | |
| Name of Individual Provider or Agency | Contact Telephone Number | Application Date *(month, day, year)* |
| Name of Person Completing the Application | Contact E-mail Address | |
| **Section A. Application Type *(Check all that apply.)*** | | |
| Initial authorization *(For respite facility, include respite facility application.)* | | |
| Reauthorization | | |
| **Section B. For Existing Providers *(Check all that apply.)*** | | |
| Conversion of Agency Type (e.g., individual provider to non-accredited agency) | | |
| Add new staff  *List names here*: | | |
| Add new service  *List services here*: | | |
| Update Demographic Information *(For update of address, name changes, or requesting county update. Include name of staff that will provide services in this county. If you need additional space, a provider summary* ***(***[***https://dmhareport.fssa.in.gov/***](https://dmhareport.fssa.in.gov/)***)*** *may be attached.)* | | |
| Add Respite Facility *(Include respite facility application.)* | | |
| Update Individual or Agency Primary Contact Information *(Check information being updated below and fill out State Form 55353, Provider Demographics.)*  Update Primary Contact: *See Section C*  Update Billing Contact: *See Section C*  Update Notice of Action (NOA) Contact*: See Section D* | | |
| Add / Edit Specialty Comment *(See Section F of State Form 55353, Provider Demographics.)* | | |
| **Section C. The following is ONLY for ACCESS SITE use and updates (*not for rendering provider information*).** | | |
| Add / Edit Access Site Main Contact  Providing access site services for the following County(s):  Provide this cover sheet and include a copy of Driver’s License, User Agreement, and full contact information here for access site person:   |  |  | | --- | --- | | Contact Name | Contact E-mail Address | | Contact Site Telephone Number | Site Address | | | |
| **Additional Provider information**:   * DMHA Youth Provider Information: <http://www.in.gov/fssa/dmha/2764.htm> * DMHA Youth HCBS Provider Module service program on Indiana Medicaid website: <http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx> | | |