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| SEAL31.TIF | **APPLICATION COVER SHEET**State Form 56583 (R3 / 10-21)  | FAMILY AND SOCIAL SERVICES ADMINISTRATIONDIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)YOUTH HOME AND COMMUNITY-BASED WRAPAROUND SERVICES (HCBS)402 W. Washington Street, Room W353Indianapolis, In 46204-2739Telephone: (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:

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| Contact Name      | Contact E-mail Address      |
| Contact Site Telephone Number      | Site Address      |

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| **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>
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