Reset Form

APPLICATION FOR CERTIFICATION AS A RESIDENTIAL CARE PROVIDER

State Form 56914 (2-20)

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF MENTAL HEALTH AND ADDICTION
CERTIFICATION AND LICENSURE
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739

INSTRUCTIONS: 1. *Complete original application and attachments.*
2. *Forward to address in upper right corner of form.*

NOTE: Once certified as a Residential Care Provider, in order to open up the residence you must apply for Sub-Acute and/or Supervised Group Living Certification. Please refer to Article 7.5 Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions for guidance.

I. GENERAL INFORMATION

Type of application
☐ New application ☐ Renewal ☐ Updating Information

Parent corporation *(if applicable)*

Legal name of applicant agency *(As on file with the Indiana Secretary of State's Office, if applicable)*

Doing Business As (DBA) name of agency, if different

Employer identification number *(if applicable)*	Type of organization *(check one)* ☐ Governmental Entity ☐ Nonprofit ☐ For Profit

Name of chief executive officer / agency director

Business telephone number ( )	Business fax number ( )	Crisis telephone number *(if applicable)* ( )	Intake or access telephone number *(if applicable)* ( )

Agency e-mail address	Agency website	Is the facility on the bus line? ☐ Yes ☐ No

II. MAIN SITE INFORMATION

Address of main site / applicant agency – main business office location / headquarters location *(A post office box number is not considered a location.) (number and street)*

City, state, and ZIP code	County

Mailing address of applicant agency *(If different from location address)*

City, state, and ZIP code	County

III. TYPES OF PAYMENT ACCEPTED

Applicants must indicate all types of payment accepted at this location. *Check all that apply.*
☐ Cash / Self Pay ☐ Private Medical Insurance ☐ Military Insurance (Tricare) ☐ Medicare ☐ Medicaid
☐ Sliding Scale Fee ☐ Other: _____

IV. AGENCY ATTESTATION

I attest that the information contained in this record is accurate, true and complete in all aspects.

Signature of person completing this application	Date *(month, day, year)*

Printed name of person completing this application	Title of person completing this application

E-mail address	Telephone number ( )

V. MISSION STATEMENT

Please insert the agency mission statement.

VI. REQUIRED DOCUMENTS

Please submit the following items from your organization.

- ☐ A description of the organizational structure and mission of your organization
- ☐ A description of the services to be provided and how your organization will provide them
- ☐ A list of governing board members including the following information
  - The governing board should be composed of at least five (5) individuals
  - At least one (1) member should be a primary or secondary consumer
  - At least one (1) member should be licensed as a physician or health services professional in psychology *(Please submit licenses.)*
- ☐ The chief executive officer should have a least a master's degree and should have demonstrated managerial experience in the mental health care or related field *(Please submit degrees and resume.)*
- ☐ List of names and positions of executive staff.
- ☐ Proof of general liability insurance coverage in the minimum amount of five hundred thousand dollars ($500,000) for bodily injury and property damage.
- ☐ A copy of the applicant's procedures to ensure protection of resident rights according to IC 12-27 and confidentiality according to IC 16-39.
- ☐ A copy of the client rights document your organization will give to consumers.
- ☐ The most recent audit of your organization which should be prepared by an independent certified public accountant.

VII. GENERAL CONDITIONS

Upon certification for the requested services(s), the applicant shall abide by all laws, rules and administrative directive governing the certified service(s). Please refer to Article 6 - Residential Care Providers Certification, 42 CFR Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records, Article 27 - Human Services, and Article 39 - Health Records as applicable.

The applicant affirms that the statements and declarations contained herein are true and correct to the best of the applicant's knowledge.

Signature of chief executive officer / owner of applicant agency	Date *(month, day, year)*