DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

APPLICATION FOR CERTIFICATION

AS A

MEDICAID PROVIDER

INSTRUCTIONS FOR APPLICATION

1. Prior to completing the enclosed application form, Provider Certification Manual Standards should be carefully studied. Unless otherwise waived, programs shall comply with these standards.

2. The application should be largely self-explanatory. The following points should be noted:

   - ❖ CORPORATE NAME: The full legal name of the program must be used.
   - ❖ PROGRAM NAME: The full official title of the program must be used.
   - ❖ ADDRESS: Give the full address of the program' headquarters. If the program uses more than one facility, provide on a supplemental sheet the addresses of facilities used.
   - ❖ TELEPHONE: Give the telephone number of the program's headquarters. If more that one facility is used, indicated the other phone numbers on a supplemental sheet.
   - ❖ NOTE: It is important that the information on this application is complete, accurate and up to date.

3. QUESTIONS OR CONCERNS SHOULD BE DIRECTED TO: Provider Relations Unit, Division of Substance Abuse and Mental Health @ 255-9789.

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
1901 N. DuPont Highway
New Castle, DE 19720

APPLICATION FOR CERTIFICATION
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Check One:

ق INITIAL APPLICATION

أ RENEWAL APPLICATION

I. PROGRAM IDENTIFICATION

A. NAME: _____

B. ADDRESS: _____
_____
_____ ZIP CODE: _____

C. TELEPHONE: Area Code (____) Number: _____

D. NPI Number_____

E. Type of Program Certification for which application is being made. Check appropriate box or boxes:

أ Assertive Community Treatment Program

أ Alcohol and Other Drugs (AOD) Day Treatment Program

أ Other (specify) _____

F. Anticipated date of eligibility for certification: _____

G. IS THE PROGRAM CURRENTLY:

أ Licensed By Whom? _____ Expiration Date: _____

أ Certified By Whom? _____ Expiration Date: _____

أ Accredited By Whom? _____ Expiration Date: _____

H. PROGRAM MANAGEMENT

1. NAME OF EXECUTIVE OFFICER: _____

   TITLE: _____

   ADDRESS: _____

   _____

   _____ ZIP CODE _____

2. NAME OF CONTACT PERSON: _____
   (If other than Executive Officer)

   TITLE: _____

   ADDRESS: _____

   _____

   _____ ZIP CODE _____

All of the following information shall be submitted with the initial application form. Items highlighted by ® should be submitted when applying for recertification.

ڤ Programs services to be provided. ® - Only if there are changes since last certification

ڤ Manual of policies and procedures in administrative, financial, personnel and program services management. ® Only those policies and procedures which have been updated

ڤ Program organization chart. ® Only if there are changes since last certification

ڤ Samples of any forms used by the program and instructions for each form

ڤ Sample client chart. ® Only if chart has changed since last certification

ڤ Corporate and/or Advisory Board By-laws. ® Only if there has been a changes since last certification.

ڤ Staff and Board meeting minutes for the six months prior to the submission of this application ®

ڤ Documentation of any current insurance policy coverage such as fire, program and clinician liability, etc. ®

ڤ Documentation of facility occupancy permit

ڤ Most recent annual audit report to include sources of funding

_____ _____

President of Governing Body/ Advisory Council

Program Director

_____ _____

Date

Date

I. STAFF

NOTE: Attach additional sheets if necessary.

NAME	TITLE	DEGREE OR CERT.	MAJOR FIELD OF STUDY	YRS OF EXP. RELATED TO POSITION	FULL-TIME	PART-TIME	CONSULTANT	CLINICIAN STATUS

J. GOVERNING BOARD AND/OR ADVISORY COUNCIL

☐ GOVERNING BOARD
☐ ADVISORY BOARD

NOTE: Indicate any relationship between a Board Member and a Staff member. Also, indicate Consumer with "C" after name and Family Member with "F" after name. Attach additional sheets, if necessary.

NAME	ADDRESS	OCCUPATION