Division of Certification
Program Modification
Application Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to make changes to existing certified programs within the public mental health system for individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/ developmental disabilities (IDD), and substance use disorders (SUD). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note: Incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file after 30 days of date received. If an application is voided, a new application must be submitted.

- DMH Certified Provider: _____

  Date of Application: _____

  DMH Certification Designation(s) Currently Held:

DMH/D ☐ DMH/H ☐ DMH/C ☐ DMH/O ☐ DMH/G ☐ DMH/P ☐ DMH/I ☐ DMH/CCBHC ☐

- **<u>Provider Contact Information:</u> Please include a single contact person responsible for this application. A primary place of business, primary and secondary telephone numbers, and valid email address must be provided. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All correspondence will be conducted with the indicated contact person or the provider's Executive Director.**

Contact Person: _____ Position: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same): _____

City: _____ State: _____ Zip Code: _____

Telephone Number (Primary): _____ (Secondary): _____

Email Address: _____

- **Assurances and signatures: As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the State of Mississippi. I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to ensure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services.**

Executive Director Signature: _____ **Date:** _____

DMH Mississippi Department of Mental Health *Supporting a Better Tomorrow...One Person at a Time*	**Application to Modify Existing Program Certification**
Change the Name of Program	
Current Certified Program to be Modified	
Current Program Certificate #	
New Name of Program (if applicable)	
Change Capacity of Program	
Certified Program to be Modified	
Current Program Certificate #	
Current Capacity	
Requested Capacity	
Reason for Change	
Required Attachments: ☐ Floor Plan for New Program (including the designated usable space with service areas marked)	
Other Documentation Included for Review:	

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Applications can be sent via email or mail to the following:

MS Department of Mental Health
239 North Lamar Street
1001 Robert E. Lee
Building Jackson, MS
39201
certification@dmh.ms.gov