Division of Certification
New Program 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 a 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 Add a New Program**
Program-Specific Information	
Name of Program to be Certified	
Physical Address of New Program	
Room Number (if applicable)	
Program Location (Name of school or building if applicable)	
Day/Hours New Program will be in Operation	
Proposed Start Date	
Requested Capacity based on usable physical space	
Targeted Population (For Day Treatment, specify ages/age-range of individuals to be served)	
List all DMH-certified services to be provided at the location (attached additional pages if needed)	

Is this location currently certified by DMH? Yes ☐ No ☐ If yes, provide Certificate Number _____

Was the location previously certified by DMH? If so, provide date(s): _____

Are any non-DMH Certified Services provided at this physical location? Yes ☐ No ☐	
(If yes is checked above) Nature/description of the non DMH- certified services being provided in this space/area/location.	
Geographic Area(s) to be Served (county, city, school districts) *If School District, must specify district wide or specific school and include a current signed copy of the MOU.	

Required Attachments:

_____ Floor Plan for New Program (including dimensions and designated usable Space with service areas clearly identified for the space being certified)

_____ **Staffing Plan, including staff qualifications and/or credentials

_____ **Job Descriptions for staff providing the New Service(s)

_____ *Site specific Permits, Licenses, Inspection Reports or other (i.e. Fire Inspection, Pest Control, etc.)

_____ *Proof of Operable Utilities

_____ (For Supervised Living) Evidence of Furnishings

*** If this Program is located in a school or licensed nursing facility, this documentation is not needed.**
**** If this type of Program has previously been certified, the above documentation is not needed.**

Other Documentation Included for Review:

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. If an application is voided, a new application must be submitted.

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