Mississippi Department of Mental Health

Supporting a Better Tomorrow...One Person at a Time

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 to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). 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. If an application is voided a new application must be submitted. The DMH certified application review process will begin 30 days from the receipt date of the application.

A. 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** ☐

B. <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 included. 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 _____ **Fax Number** _____

C. <u>Assurances and Signatures:</u> 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 (documentation attached). 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 assure 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 in Physical Location

Current Certified Program to be Modified	
Current Program Certificate #	
Physical Address of New Location	
List all DMH – certified services to be provided at the locations **(attach additional pages if needed)**	

Is The New Location Currently Certified by DMH? Yes_____ If yes, Provide Certificate Number_____

No_____

Was the New Location Previously Certified by DMH? If so, provide date(s)_____

Are any non-DMH certified services provided at this physical location? ☐ **Yes** ☐ **No**

Nature/description of the non-DMH – certified services	
Requested Capacity	
Proposed Change Date	

Required Attachments:

_____ **Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified)**

_____ **Site Specific Permits, Licenses, Inspection Reports or other**

_____ **Proof of Operable Utilities**

_____ **(For Supervised Living) Evidence of Furnishings**

Other Documentation Included for Review:

Change the Name of Program	
Current Certified Program to be Modified	
Current Program Certificate #	
New Name of Program	
Change Capacity of Program	
Current Certified Program to be Modified	
Current Program Certificate #	
Current Capacity	
Requested Capacity	
Reason for Change	
Required Attachments: _____ **Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified)**	
Other Documentation Included for Review:	

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