Mississippi Department of Mental Health
Division of Certification
Full-Time Employment Attestation Form

INSTRUCTIONS: This form should be utilized for all agency providers certified to provide services 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. This Attestation Form should be completed by the Executive Director/Top-Level Administrator to assure the Executive Director/Top-Level Administrator is employed by the agency provider full-time (Rule 2.8.G.14). All attachments should be submitted with the completed application. Please type or print legibly. This form must be completed by the individual or governing body with the authority and responsibility for developing policies, procedures, and business practices for which the agency and its services will be operated. This may include the executive director, chairperson of the governing authority, owner, etc. All dates should include the month, date, and year. Original signatures must be included. This form should be completed, signed, and submitted as part of the Interested Agency Provider application packet.

Section A

Full-Time Employment Attestation Form: Please include the contact information for the Executive Director who is signing this Full-Time Employment Attestation Form certifying that he/she is employed by the agency provider on a full-time basis.

Agency Name: _____

Executive Director/Top-Level Administrator Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same as street address): _____

City: _____ State: _____ Zip Code: _____

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

Email Address: _____

Section B

Attestation of Full-Time Employment: This certification is to be read, signed, and dated by the Executive Director.

I, the undersigned, hereby attest that I am employed full-time as the Executive Director of the above-named agency provider. My role and responsibilities include overseeing the daily operations, ensuring compliance with all applicable regulations and standards, and leading the agency in fulfilling its mission and objectives.

I confirm that my employment with the above-named agency provider is on a full-time basis, and I am dedicated to the effective management and administration of the agency's programs and services.

Signature	Date

Type or Print Name and Title of Individual Signing

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Witness Signature:
Name: _____ **Title:** _____ **Date:** _____

For DMH Use Only:
Received By: _____ **Date:** _____

Please carefully review the Application and the required attachments outlined in the Application Checklist before submission. All components of the Application Packet must be submitted via the DMH Interested Provider Portal, which can be accessed on the DMH website (www.dmh.ms.gov) before the application is considered complete. Incomplete applications will not be processed.