Mississippi Department of Mental Health
Division of Certification
Interested Provider Application Checklist

INSTRUCTIONS: This Application Checklist form should be used in conjunction with the Interested Provider Application to apply to DMH to initiate the process to become 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. All attachments should be submitted with the completed application. Please type or print legibly. This application 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. If additional space is needed to respond, please provide the information as attachments and reference the application section. Ensure all items are complete and included in the application packet. Submit the application packet through the Interested Agency Provider Portal, per the instructions outlined in the portal. This form should be completed, signed, and submitted as part of the Interested Agency Provider Application Packet.

Section A

Contact Information: Please include the contact information for the Executive Director/Top-Level Administrator who is submitting the Interested Provider Application.

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

Interested Provider Application Checklist: This checklist should be used to ensure all required forms and documentation are included in the Interested Agency Provider Application Packet. Incomplete Application Packets will be voided.

1. DMH Interested Agency Provider Application: ______
   Complete and signed application form.

2. Evidence of Incorporation: ______
   Documentation from the Mississippi Secretary of State's Office.

3. Governing and Professional Authority Structures: ______
   Names and positions. Signed statement of Governing Authority and Executive Director Assurances.

4. Organizational Chart: ______
   Identifies agency leadership by position and name with delineated lines of authority.

5. Attestation to DMH Data Submission Requirements Form: ______
   Agreement to adhere to DMH's data submission requirements.

6. Point of Contact Information Form: ______
   Name and contact information of the person associated with the agency provider for DMH Certification matters.

7. Signed Releases of Information: ______
   As may be required by DMH.

8. Professional Credentials Verification: ______
   Official transcripts, verifiable copies of required professional credentials, and/or completed DMH verification of experience forms.

9. Agency Policies and Procedures: ______
   Address applicable DMH *Operational Standards* general rules, chapters, and program-specific chapters.

10. Proof of Criminal Background Checks Form: ______
    For each position outlined in the Interested Agency Provider Orientation, with no disqualifying events.

11. Evidence of Current Licensure/Certification: ______
    From all other states/entities in which the agency provider/business operates, as applicable.

12. Professional References: ______
    Three (3) professional references from entities/individuals that maintain a business relationship with the applicant.

13. Signed Statement of Assurance: ______
    From the agency Executive Director (or top-level administrator) that the Executive Director/Top-Level Administrator has read all applicable sections of the DMH *Operational Standards*, understands the rights of people served by the agency provider and ethical and professional conduct as outlined in Chapter 14, and will abide by the Health, Environment, and Safety rules and requirements in Chapter 13.

14. Executive Director Full-Time Employment Attestation Form: ______
    Signed and completed form.

15. Requested Agency Job Descriptions: ______
    Detailed job descriptions for all positions.

16. Signed Business Associate Agreement: ______
    As applicable, based on provider type and services provided.

17. Proposed Budget and Operating Expenses Documentation: ______
    Proposed budget; Documentation of three (3) months of operating expenses based on the proposed budget.

18. Fiscal Requirements Documentation: ______
    Evidence of systems in place for control of accounts receivable/payable, handling of cash, credit arrangements, discounts, write-offs, billings, and individual accounts.
    For entities currently in operation: Most recent six (6) months of bank statements and audited financial statements with an unqualified opinion from a Certified Public Accountant (CPA).
    For entities not currently in operation: Proforma Financial Statements compiled by a CPA and documentation of planned resources for three (3) months of operating expenses.

19. Additional Application Items: ______
    Any other items as required through the Interested Agency Provider application submission process.

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Section C

Additional Information: If you did not submit one or more of the required documents/information, please provide an explanation for the delay or the reason for non-submission.

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Section D

Certification of Completed Interested Provider Application Packet: This certification is to be read, signed, and dated by the Executive Director/Top-Level Administrator. The individual signing must be the proprietor in the case of a sole proprietorship, the Executive Director or chair of the governing authority of a corporation, governmental entity, or individual identified and granted authority by the University.

I certify that this form and its attachments have been carefully completed and reviewed. To the best of my knowledge, the information contained in this application and its attachments is true, accurate, and complete.

Signature	Date

Type or Print Name and Title of Individual Signing

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.

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