ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER RE-CERTIFICATION BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be submitted to renew DBHS certification after receiving re-accreditation from the national accrediting agency at the time of the new accreditation cycle.

Name of Agency:

_____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Administrative Address: _____

Telephone: _____ Fax: _____

E-mail: _____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission (J-CO)

____ Commission on Accreditation for Rehabilitation Facilities (CARF)

____ Council on Accreditation (COA)

2. Date of most recent survey: _____

3. National Accreditation Period: _____ through _____

4. The accredited provider is located within the state of Arkansas.

_____ Yes _____ No

Chief Executive Officer (or equivalent) Certification: By my signature I certify that all information contained in this form and in all attachments are correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Qualification Form for RSPMI Provider Re-Certification

All of the following information must be attached to the Qualification DBHS Form 3 for RSPMI Re-Certification. Applications must be submitted in full. Partial submissions will not be accepted.

1. Latest accreditation survey results. (The entire survey report with a listing of all provider service sites providing outpatient mental health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery.

4. All Evidence of Compliance, Measures of Success, Quality Improvement Plans, and any Corrective Action Plans that were required and submitted to the accrediting organization pertaining to outpatient behavioral health services related to the latest accreditation survey.

5. Identify any significant changes (since last certification period) in program resources (i.e. number of sites operated by agency, changes in administrative staff, and number of school-based Mental Health Programs). Please attach additional pages if needed.

6. Identify any significant changes (since last certification period) in personnel qualifications and resources (i.e. changes in code of ethics and client grievance policy, changes in how psychological testing services are delivered and changes in the plan for staff training and supervision). Please attach additional pages if needed.

7. Identify any significant changes (since last certification period) in the physical plant(s). (i.e. changes in address and phone numbers of service delivery sites, any structural/cosmetic changes). Please attach additional pages if needed.

8. Describe any significant changes (since last certification period) in the service delivery plan (i.e. types of services available at each site, changes in the crisis services plan and any plans for expansion or reduction in services). Please attach additional pages if needed.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send a cover letter and all application materials to be re-certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF POLICY AND CERTIFICATION

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Division of Behavioral Health Services, Policy and Certification Office, for the specific purpose of obtaining or sharing information relevant to RSPMI Provider Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

_____ _____
Signature of CEO (or equivalent) Date

_____ _____
Signature of Witness Date