

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF BEHAVIORAL HEALTH SERVICES  
NOTIFICATION FORM FOR CLOSING OR MOVING OF  
AN RSPMI PROVIDER SITE**

Moving a site constitutes a closing of one site and a move of the program(s), move of existing staff and move of existing client base to another location. If a provider relocates a currently certified site within a fifty (50) mile radius the accrediting agency, DBHS and Medicaid must be notified thirty (30) days prior to that relocation. Neither an on-site survey nor a new Medicaid number is required in order to extend certification to the moved location.

**Name of Agency:** \_\_\_\_\_

**Chief Executive Officer** (or equivalent): \_\_\_\_\_

**Corporate Compliance Officer** (or equivalent): \_\_\_\_\_

**Administrative Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**This is notification that the following site(s) have:** \_\_\_\_\_ moved \_\_\_\_\_ closed

**CLOSING Date of Closing:** \_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MOVING Date of Move:** \_\_\_\_\_

PREVIOUS ADDRESS (Include: street, city, county, telephone & fax) NEW ADDRESS

\_\_\_\_\_  
\_\_\_\_\_

**Please attach all documentation to and from your accrediting organization regarding the above information. Certification will not be granted to the new site address until all information from the accrediting organization indicates that the new site address is accredited.**

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

\_\_\_\_\_  
Signature of Chief Executive Officer (or equivalent) Date

\_\_\_\_\_  
Name of Chief Executive Officer (or equivalent) typed or printed

**Page Two**  
**Notification Form for Closing/Moving**

1. In addition to this form, please provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.
2. Include a photograph of outside entrance to building, staff offices, and waiting area for all new site locations.

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

Please send this form with required documentation to the following address:

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