Arkansas Department of Human Services

Application for Behavioral Health Agency Certification

To be completed upon initial application to become certified as a Behavioral Health Agency

Name of Agency:_____

Chief Executive Officer (or equivalent):_____

Corporate Compliance Officer (or equivalent):_____

Administrative Address:_____

Physical Address:_____
Street Address City State Zip

Mailing Address:_____
Street Address City State Zip

County:_____ Phone:_____ Fax:_____

E-mail: _____ Website:_____

TIN #: _____

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

____The Joint Commission (TJC)
____Commission on Accreditation for Rehabilitation Facilities (CARF)
____Council on Accreditation (COA)

Date(s) of most recent survey:_____

Accreditation Period:_____

The accredited provider is located within the State of Arkansas.
_____ Yes _____ No

As the **Chief Executive Officer** (or equivalent) of the agency named above, 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

Required Documentation

All of the following information must be attached to the Behavioral Health Agency Certification. Applications not submitted in their entirety will not be processed. Incomplete applications will be returned to the applicant without review.

1. Latest accreditation survey results. (The entire survey report covering outpatient behavioral health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to the DHS) 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 DHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery. (See DHS BEHAVIORAL HEALTH AGENCY Form 200)

4. All Evidence of Compliance, Measures of Success, Performance Improvement Plans, and any Corrective Action Plans submitted to the accreditation organization pertaining to outpatient behavioral health services.

5. Behavioral Health Agency Services and Resource Summary Report with all attachments as designated in the Behavioral Health Agency Services and Resource Summary Form (DHS BEHAVIORAL HEALTH AGENCY Form 210).

DHS WILL REVIEW THIS APPLICATION WITHIN NINETY (90) CALENDAR DAYS OF RECEIPT.

DHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

Please send a cover letter and all application materials to be certified by DHS as a Behavioral Health Agency to one of the following addresses:

Email to DPSQA.ProviderApplications@dhs.arkansas.gov

or

Arkansas Department of Human Services
Division of Provider Services and Quality Assurance
ATTN: Licensure and Certification
P.O. Box 8059, Slot S408
Little Rock, AR 72203