Arkansas Department of Human Services

Behavioral Health Agency Added Location Application

Name of Agency:____

Chief Executive Officer (or equivalent):_______________________________________

Corporate Compliance Officer (or equivalent):__________________________________

Physical Address:____

Street Address City State Zip

Mailing Address:____

Street Address City State Zip

County:____________________ Phone:_____________________ Fax:________________

Email: ____________________________

Date New Site Opened/planned:____

Chief Executive Officer (or equivalent) Certification: By my signature, I certify that I have reviewed this application and attachments, and to the best of my knowledge it represents an accurate report of agency services and resources.

____

Signature of Chief Executive Officer (or equivalent) Date

____

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

PERSONNEL RESOURCES FOR NEW SITE ONLY (As of the date this report is submitted)	**SFY** _______________
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Independently Licensed Clinicians	
5. Non-Independently Licensed Clinicians	
6. Registered Nurses	
7. Qualified Behavioral Health Providers (Including Certified Peer Support Specialist, Certified Youth Support Specialist, Certified Family Support Partners)	
8. All other staff not included above	
9. Sum of lines 1-8	
PROGRAM RESOURCES FOR NEW SITE ONLY (Round to nearest whole number)	
10. Number of counties in service area	
11. Number of counties in service area in which agency operates a service site	
12. Total number of service sites operated by Agency	
13. Average daily clients served by Agency	
14. Number of School Based Behavioral Health Programs run by agency	
15. Total projected daily average of clients in all school based sites combined	
16. Total projected number of clients served in the outpatient clinic	
17. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, partial hospitalization, therapeutic communities, etc.)	
17.A.	
17.B.	
17.C	
17.D	
If more room is needed, please list on a separate page and attach to this report.	
CONTACT INFORMATION	
18. Contact person regarding this report	
19. Telephone number of contact person for this report	
20. E-mail address of contact person for this report	

PHYSICAL PLANT

1. Attach a list of all new service delivery sites including each site's address (street, city & county), telephone number, the name of the designated contact person, for each site and that person's email address, and the Outpatient Behavioral Health services available at each site.

2. Attach a photograph of each service delivery site for which you are requesting a certification extension. Include outside entrance to building, staff offices, and waiting area.

ACCREDITATION INFORMATION

I. Attach documentation notifying your accrediting organization of the site(s) additions and the accrediting organization's acknowledgement of the accreditation extension. Certification extension **WILL NOT BE GRANTED** until you have the accrediting organization's documentation.

II. Include dates of current accreditation cycle.

Reimbursement by Arkansas Medicaid services shall not occur until the site is certified by the Department of Human Services.

Please send this form along with your application to be certified by DHS as a Behavioral Health Agency to the following address:

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