**Attestation**

|  |  |
| --- | --- |
| To: | DPSQA Licensure and Certification |
| From: |  |
| CC: |  |
| Date: |  |
| Re: | OBHA to CSSP |

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, am attesting that I am enrolled as an Outpatient Behavioral Health Agency (OBHA), providing one or more of the services listed below, and meet the certification requirements of Enhanced CSSP Agency. I am requesting provisional Enhanced CSSP Agency certification until July 1, 2023. I understand that in order to continue certification at the CSSP Enhanced level, a site visit must be completed by DPSQA at the certified facility before July 1, 2023.

Agency Name:

Agency OBHA DPSQA Identification number:   
Agency Therapeutic Communities Identification number:   
Agency Residential Community Reintegration Identification number:  
Agency Partial Hospitalization Identification number:

Enhanced Services being Provided (check all that apply):  
Adult Rehabilitation Day \_\_\_\_\_\_\_  
Therapeutic Communities \_\_\_\_\_\_\_  
Residential Community Reintegration \_\_\_\_\_\_\_  
Partial Hospitalization \_\_\_\_\_\_\_

Please sign and upload with CSSP application. <https://arkdhs.force.com/elicensing/s/>

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

Signature Date