



**ACCESS TO
RECOVERY**

ATR III RS Provider Credential Renewal

Instructions

- Please type and email completed renewal packet to: mark.shields@dmh.mo.gov
- Retain a copy of the completed renewal for your files.

Questions can be directed to the Division of Alcohol and Drug Abuse at (573) 751-4942.

1. AGENCY IDENTIFICATION

ORGANIZATION NAME	
RECOVERY SUPPORT PROGRAM NAME (if different than above)	DATE RECOVERY SUPPORT PROGRAM ESTABLISHED
RECOVERY SUPPORT PROGRAM DIRECTOR	CONTACT PERSON REGARDING CREDENTIALING (IF DIFFERENT)
RECOVERY SUPPORT PHYSICAL ADDRESS STREET	MAILING ADDRESS (IF DIFFERENT) STREET
CITY STATE ZIP CODE	CITY STATE ZIP CODE
TELEPHONE NUMBER MAIN ()	E-MAIL
FAX NUMBER ()	WEBSITE (OPTIONAL)
CELL () OPTIONAL (FOR DMH PERSONEL; WILL NOT BE PUBLISHED)	

2. ADMINISTRATION

NAME OF ORGANIZATION'S LEADER OR DIRECTOR	TITLE
YEAR ORGANIZATION WAS ESTABLISHED	DATE OF INCORPORATION WITH STATE OF MISSOURI
CURRENT NUMBER OF BOARD MEMBERS OR GOVERNING BODY MEMBERS	NAME AND CONTACT INFORMATION OF PRESIDENT OR CHAIRPERSON OF BOARD OF DIRECTORS NAME: TITLE: ADDRESS: CITY/STATE/ZIP: PHONE:
NAME OF PARENT CORPORATION (IF APPLICABLE)	
ADDRESS OF PARENT CORPORATION STREET	
CITY STATE ZIP CODE	

3. TYPE OF ORGANIZATION

Place a check mark in the box that best describes your organization. Choose one answer per line.

<input type="checkbox"/>	FAITH-BASED *	<input type="checkbox"/>	COMMUNITY-BASED
<input type="checkbox"/>	GRASS-ROOTS***	<input type="checkbox"/>	CORPORATE
<input type="checkbox"/>	NON-PROFIT	<input type="checkbox"/>	FOR-PROFIT

* If you are a faith based provider, please indicate type of faith (example Christian, Muslim, etc.)

Type of Faith: _____

Denomination or Sect (example: Catholic, Baptist, etc.)

Denomination or Sect: _____

*** Grassroots organization has an annual budget of less than \$500,000.00 per year.

4. LOCATION OF ADDITIONAL PROGRAM SITES (attach additional page as necessary)

PROGRAM NAME	ADDRESS STREET CITY ZIP	COUNTY	TELEPHONE	FAX NUMBER	TYPE OF RECOVERY SUPPORTS OFFERED	HOURS OF OPERATION

6. RECOVERY SUPPORT SERVICES

Previously credentialed for this service?	Requesting credentials for this service under ATR III?	Recovery Support Service
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Care Coordination
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Re-Entry Coordination
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Drop-In Center
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Family Engagement-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Family Engagement-Group
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Housing-Peer
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Housing-Supervised
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Peer Support-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Recovery Coaching-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Recovery Counseling-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Recovery Counseling-Group
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Recovery Education-Group
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Spiritual Counseling-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Spiritual Counseling-Group
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Spiritual Life Skills-Group
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Transportation-Mileage
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Transportation-Public
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Work Prep-Individual
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Future Plans <input type="checkbox"/>	Work Prep-Group

7. SUBMISSION CHECKLIST--ATTACH COPIES OF THE FOLLOWING—As applicable to the services you will be providing

Attached	Not Attached	Not Applicable	Documentation Required
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inspection report by a fire authority that the facility complies with the applicable local/state codes. (Annual inspections required for all properties.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupancy and/or zoning permit from the local government (all properties).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	State of Missouri Certificate of Good Standing.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staff/ volunteer information; proof of eligibility to work in the US, background checks, relevant educational credentials, certifications, licensure, ordination, training certificates.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Proof of appropriate driver's license and proper automobile insurance (if providing transportation).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HQS Housing inspection approval (HUD certified inspection).

Use the submission checklist above to determine if your application is ready to submit. If you have marked NOT ATTACHED in any row, your application is not ready to submit and will be returned to you. All application components are required to be included before your application will be considered.

8. SIGNATURES

(Agency Name) _____ hereby applies for Credentialed Status by the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse as an ATR Recovery Support Program in accordance with applicable credentialing requirements. The agency agrees and understands that agents of the Division of Alcohol and Drug Abuse may inspect the premises, review agency and personnel and client records, observe program operations, and interview employees and clients associated with the program(s). The agency agrees to comply with all written recommendations and requirements regarding compliance with credentialing requirements, as noted in reports issued by the Department of Mental Health, Division of Alcohol and Drug Abuse.

SIGNATURE—CHIEF ADMINISTRATIVE OFFICER	DATE
SIGNATURE—GOVERNING BODY OR BOARD PRESIDENT	DATE