



**Missouri Department of Mental Health
Office of Licensure and Certification**

Application for **DD Medicaid Waiver Certification** - Instructions

- ❖ Please complete and return all applications promptly. **Please return the information packet to us at least 60 days prior to the expiration date of your certificate.**
- ❖ Before we can accept your application for processing, it must be complete. **The application will be returned to you requesting inclusion of any missing information.** If a section is not applicable to your agency/ facility, please note that with an N/A in those sections. Print clearly and legibly using black ink or type.
- ❖ The Application for Certification is now available online at the following websites <http://dmh.mo.gov/dd/provider/> or <http://dmh.mo.gov/dd/forms.html>. The form allows you to fill it in electronically, print it, and sign it with an original signature.
- ❖ **Secretary of State Registration:**
 - To determine if registration is required, go to the Secretary of State website: www.sos.mo.gov.
 - To find Charter # and Expiration Date, go to <https://bsd.sos.mo.gov/BusinessEntity/BESearch.aspx?SearchType=0>
- ❖ **Fire/Safety Inspections:**
 - Send proof of payment, if paid by means other than city/county taxes, for fire coverage of all sites served by a volunteer or subscription fire department.
 - **After processing** your completed application, if a request for fire/safety inspection is required, the Office of Licensure and Certification will submit the request to the State Fire Marshal's office.
 - Those required to have a fire/safety inspection are:
 - Group Home
 - Independent Living Skills Development (onsite)
 - Community Employment (onsite)
 - Those **not** required to have a fire/safety inspection are:
 - Individualized Supported Living (4 persons or less)
 - Group Home (3 persons or less)
- ❖ **Conviction of Felony**
 - For any persons named on the application with a felony background, submit an explanation.
- ❖ Check **ALL** services applicable to your certification on Page 1.

- ❖ Complete addresses for **ALL** sites on Page 2.
 - Site name (if other than agency name);
 - Address (must include a physical street address, city, zip code, and county);
- ❖ The completed application packet should include:
 - Application for Certification
 - Copy of Organizational Chart
 - **New or Updated** Policies
- ❖ **Mail the completed application packet to:**

**Missouri Department of Mental Health
Office of Licensure and Certification
PO Box 687
Jefferson City, MO 65102**

If you have questions regarding your DD Medicaid Waiver Certification application, please contact **Judy Scheulen**, Office of Licensure and Certification, at (573) 751-4024.



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
 1706 E. ELM STREET, PO BOX 687
 JEFFERSON CITY, MISSOURI 65102

APPLICATION FOR CERTIFICATION

| DMH USE ONLY | |
|--------------|-----------------|
| LCRO | EXPIRATION DATE |
| IDENTIFIER | |

| | | | | | |
|---|--|---|-------|--|------|
| NAME OF ORGANIZATION | | TELEPHONE NUMBER | | FAX NUMBER | |
| NAME OF CHIEF ADMINISTRATIVE OFFICER | | COUNTY | | EMPLOYER TAX ID NUMBER | |
| ADDRESS OF AGENCY/FACILITY (ADMINISTRATIVE SITE) | | CITY | | STATE | |
| BILLING/MAILING ADDRESS | | CITY | | STATE | |
| CONTACT PERSON OF ORGANIZATION | | TELEPHONE NUMBER | | TITLE | |
| E-MAIL ADDRESS | | WEB SITE | | | |
| GOVERNING BODY PRESIDENT | | ADDRESS | | CITY | |
| | | | | STATE | |
| | | | | ZIP CODE | |
| NAME OF CORPORATE OWNER, IF APPLICABLE | | | | | |
| ADDRESS OF CORPORATE OWNER | | CITY | | STATE | |
| | | | | ZIP CODE | |
| SECRETARY OF STATE REGISTRATION | | | | CHARTER # | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT IS YOUR CHARTER # AND EXPIRATION DATE? | | | | EXPIRATION DATE | |
| FIRE SAFETY: ARE ANY RESIDENTIAL OR DAY SERVICE SITES SERVED BY A VOLUNTEER FIRE ASSOCIATION OR SUBSCRIPTION FIRE DEPARTMENT? | | | | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ATTACH DOCUMENTATION OF CURRENT CONTRACT OR PROOF OF MEMBERSHIP FOR EACH SITE. | | | | | |
| OTHER LICENSING, CERTIFYING OR ACCREDITING BODY (NON-DMH) | | FACILITY/PROGRAM TYPE | | EFFECTIVE DATE | |
| | | | | EXPIRATION DATE | |
| | | | | | |
| HAS ANY PERSON NAMED ON THIS APPLICATION BEEN CONVICTED OF A FELONY? | | | | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE SUBMIT EXPLANATION. | | | | | |
| ARE THERE ANY SERVICES/PROGRAMS OF YOUR AGENCY FOR WHICH YOU ARE NOT REQUESTING CERTIFICATION OR ACCREDITATION? | | | | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN WHY: | | | | | |
| IS THE FACT THAT NOT ALL SERVICES OF YOUR AGENCY ARE CERTIFIED OR ACCREDITED MADE CLEAR TO INDIVIDUALS RECEIVING THOSE SERVICES? | | | | | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO HOW IS THIS DONE? _____ (PLEASE SUBMIT A COPY OF YOUR AGENCY'S BROCHURE FOR REVIEW.) | | | | | |
| CHECK ALL SERVICES FOR WHICH APPLICATION IS BEING MADE. | | | | | |
| DEVELOPMENTAL DISABILITIES SERVICES | | | | | |
| <input type="checkbox"/> Individualized Supported Living (ISL) | | <input type="checkbox"/> Community Employment | | <input type="checkbox"/> Indep. Living Skills Dev. | |
| <input type="checkbox"/> Group Home | | <input type="checkbox"/> Job Discovery | | <input type="checkbox"/> Respite | |
| <input type="checkbox"/> Host Home | | <input type="checkbox"/> Job Preparation | | | |
| SIGNATURE | | | TITLE | | DATE |



STATE OF MISSOURI
 DEPARTMENT OF MENTAL HEALTH
DD MEDICAID WAIVER CERTIFICATION
DESCRIPTION OF PROGRAM

| LIST THE ADDRESSES OF ALL APPROVED SERVICE DELIVERY SITES AND THE SERVICES OFFERED AT EACH SITE. | | | |
|---|-------------------------------|-------------------------|--------|
| SITE NAME | SERVICES OFFERED AT THIS SITE | CONTACT NAME | |
| SITE LOCATION (PHYSICAL ADDRESS) | CITY | ZIP CODE | COUNTY |
| PHONE NUMBER | NUMBER OF PARTICIPANTS | SPECIAL ACCOMMODATIONS* | |
| SITE NAME | SERVICES OFFERED AT THIS SITE | CONTACT NAME | |
| SITE LOCATION (PHYSICAL ADDRESS) | CITY | ZIP CODE | COUNTY |
| PHONE NUMBER | NUMBER OF PARTICIPANTS | SPECIAL ACCOMMODATIONS* | |
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| PHONE NUMBER | NUMBER OF PARTICIPANTS | SPECIAL ACCOMMODATIONS* | |
| SITE NAME | SERVICES OFFERED AT THIS SITE | CONTACT NAME | |
| SITE LOCATION (PHYSICAL ADDRESS) | CITY | ZIP CODE | COUNTY |
| PHONE NUMBER | NUMBER OF PARTICIPANTS | SPECIAL ACCOMMODATIONS* | |

ATTACH ADDITIONAL PAGES AS NEEDED.
 *Indicate additional supports needed (i.e., interpreters, communication devices, adaptations, etc.)

List the Regional Office(s) and SB40, if applicable, for which your agency provides services and the Support Coordinators that work with your agency.

| |
|---------------------|
| REGIONAL OFFICE |
| SB 40 |
| SUPPORT COORDINATOR |
| REGIONAL OFFICE |
| SB 40 |
| SUPPORT COORDINATOR |