



STATE OF MISSOURI  
 DEPARTMENT OF MENTAL HEALTH  
 DIVISION OF BEHAVIORAL HEALTH  
 1706 E. ELM ST. P.O. BOX 687  
 JEFFERSON CITY, MO 65102

**OFFICE USE ONLY**

DATE RECEIVED: \_\_\_\_\_

INITIAL/RENEWAL: \_\_\_\_\_

**SUBMISSION INSTRUCTIONS: Please submit your application and required attachments using one of the following two methods:**

- 1) Complete application, print, and mail to the above address along with all required attachments (NO STAPLES PLEASE).
- 2) Print the completed application and the required attachments scan all printed documents and email the PDF to: [dbhcertainment@dmh.mo.gov](mailto:dbhcertainment@dmh.mo.gov).

NOTE: Agencies with SATOP renewal fees may email their application but must mail their fee to the address above.

**APPLICATION FOR CERTIFICATION—NON-ACCREDITED AGENCIES**

NAME OF ORGANIZATION (NAME ON CERTIFICATE OF GOOD STANDING)	TELEPHONE NUMBER	FAX NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

ORGANIZATION TYPE  
 FOR PROFIT  NOT FOR PROFIT

NAME OF CHIEF ADMINISTRATIVE OFFICER	EMAIL ADDRESS	AGENCY WEBSITE ADDRESS
<input type="text"/>	<input type="text"/>	<input type="text"/>

ORGANIZATION ADDRESS (ADMINISTRATIVE SITE)	CITY	STATE/ZIP CODE	COUNTY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

ORGANIZATION MAILING ADDRESS	CITY	STATE/ZIP CODE	EMPLOYER TAX ID NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CONTACT PERSON FOR ORGANIZATION	TITLE	EMAIL	TELEPHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

GOVERNING BODY PRESIDENT (REQUIRED)	STREET ADDRESS	CITY	STATE/ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

GOVERNING BODY PRESIDENT EMAIL	NAME OF CORPORATE OWNER (IF APPLICABLE)	STREET ADDRESS
<input type="text"/>	<input type="text"/>	<input type="text"/>

CITY	STATE/ZIP CODE
<input type="text"/>	<input type="text"/>

PLEASE ATTACH OTHER LICENSING, CERTIFYING OR ACCREDITING BODIES (NON-DMH) ALONG WITH MOST RECENT SURVEY REPORT FROM EACH OF THE NAMED ENTITIES. INCLUDE FACILITY/PROGRAM TYPE, EFFECTIVE DATE AND EXPIRATION DATE.

ARE THERE ANY COMPONENTS/PROGRAMS OF YOUR AGENCY FOR WHICH YOU ARE NOT REQUESTING CERTIFICATION OR ACCREDITATION?  
 YES  NO IF YES, PLEASE ATTACH AN EXPLANATION.

IF SOME OF THE COMPONENTS OF YOUR AGENCY ARE NOT CERTIFIED OR ACCREDITED, IS IT MADE CLEAR TO INDIVIDUALS RECEIVING THOSE SERVICES?  
 YES  NO IF YES, PLEASE ATTACH HOW THIS IS DONE.

(PLEASE SUBMIT A COPY OF YOUR AGENCY'S BROCHURE FOR REVIEW)

HAS ANY PERSON NAMED ON THIS APPLICATION BEEN CONVICTED OF A FELONY?  YES  NO IF YES, PLEASE ATTACH AN EXPLANATION.

CHECK ALL PROGRAMS FOR WHICH APPLICATION IS BEING MADE AND INDICATE CAPACITY WHERE NOTED.

## MENTAL HEALTH SERVICES

- COMMUNITY PSYCHIATRIC REHABILITATION PROGRAM – ADULT
- COMMUNITY PSYCHIATRIC REHABILITATION PROGRAM – CHILDREN AND YOUTH
- OUTPATIENT MENTAL HEALTH
- ACCESS CRISIS INTERVENTION
- PSYCHOSOCIAL REHABILITATION – ADULT CAPACITY
- PSYCHOSOCIAL REHABILITATION – YOUTH/CHILDREN CAPACITY

## ALCOHOL AND DRUG ABUSE SERVICES

- DETOXIFICATION – SOCIAL SETTING CAPACITY
- DETOXIFICATION – MODIFIED MEDICAL CAPACITY
- DETOXIFICATION – MEDICAL
- OPIOID – CERTIFICATION
- OPIOID CERTIFICATION AND ACCREDITATION
- RESIDENTIAL TREATMENT PROGRAM (Non-Contracted) RESIDENTIAL SUPPORT CAPACITY
- OUTPATIENT – COMMUNITY – BASED PRIMARY TREATMENT – LEVEL I (must offer a minimum of 25 hours per week)
  - With Residential Support CAPACITY
  - Without Residential Support
- OUTPATIENT – INTENSIVE OUTPATIENT REHABILITATION – LEVEL II (must offer a minimum of 10 hours per week)
- OUTPATIENT – SUPPORTED RECOVERY – Level III (must offer a minimum of three hours per week)
- PREVENTION – PRIMARY (complete addendum V)
- PREVENTION – TARGETED (complete addendum V)
- PREVENTION – STATEWIDE RESOURCE CENTER (complete addendum V)
- CSTAR – GENERAL POPULATION
- CSTAR - ADOLESCENT
- CSTAR - OPIOID
- CSTAR – WOMEN AND CHILDREN
- COMPULSIVE GAMBLING
- INSTITUTIONAL CORRECTIONS

### SATOP AGENCIES PLEASE COMPLETE ADDENDUM VI

- SATOP – OFFENDER MANAGEMENT UNIT (OMU)
- SATOP – OFFENDER EDUCATION PROGRAM (OEP)
- SATOP – WEEKEND INTERVENTION PROGRAM (WIP)
- SATOP – ADOLESCENT DIVERSION EDUCATION PROGRAM (ADEP)
- SATOP – CLINICAL INTERVENTION PROGRAM (CIP) (Indicate above the corresponding outpatient level of care)
- SATOP – YOUTH CLINICAL INTERVENTION PROGRAM (YCIP) (Indicate above the corresponding outpatient level of care)
- SATOP – REACT SCREENING UNIT (RSU)
- SATOP – REACT EDUCATION PROGRAM (REP)
- SATOP – SROP/LEVEL IV (contracted but not certified)

# Certification Addendum I

## ACKNOWLEDGEMENT STATEMENT

*Agency Name*

Hereby applies for certification from the Missouri Department of Mental Health, has read the foregoing application, and agrees that the statements contained therein are true and correct and gives assurance of the ability and intention to comply with the laws applicable to certified facilities and the regulations established thereunder. It is understood that this agency will be eligible for certification only after it has complied with the requirements of the law and the applicable regulations and codes, and that such certification is subject to revocation at any time this agency fails to comply with the law, regulations or codes. Furthermore, it is agreed that agents of the Department of Mental Health are authorized by law to make inspections of premises; review agency, personnel and client records; observe program operations; interview employees and clients about the program(s); and audit the financial records of this agency in order to determine compliance with standards or to investigate any complaints. It is understood that this agency will comply with all regulations contained in the survey reports completed by authorities of the Department of Mental Health and submitted to the agency.

*Chief Administrative Officer Signature*

*Date*

*Governing Body President Signature*

*Date*

## Certification Addendum II

### LOCATION OF PROGRAMS SITES

Please attach a list of your current sites. Include program name, site, physical address, services offered, contact person, telephone & fax number, and days/hours of operations. (*See example of table below.*)

Note: The "Services Offered" column should match the programs identified on page 2 of this certification application.

Site/Program Name	Street, City, Zip, County	Services Offered at Site <small>(For Substance Abuse Treatment programs, include Level of care provided at each site)</small>	Contact Person for Site	Telephone & Fax Number	Days/Hours of Operation	Number of Residential Beds

## Certification Addendum III

### DESCRIPTION OF PROGRAM

Please submit an agency brochure and provide a list of all services and/or programs provided by the agency that are to be certified, with a description of each service. (*See example of table below.*)

Service or Program	Description of Service

# Certification Addendum IV

## PERSONNEL ALLOCATION FORM

Total number of staff, including full-time and part-time

Total number of full-time equivalent positions (FTE)

- Please attach a current table of organization, which identifies the name of the person filling each position and lines of supervision, including any current vacancies.
- Be sure to list all personnel, including full-time, part-time, consultants, volunteers, technicians, administrative, secretarial, practicum/intern students, all contracted staff and all maintenance employees. (*See example table below*).

Last Name, First Name	Title (SATOP-QI/QP)	Hire Date	Hours Per Week	Program Assigned & % of Hours in Program	Education (Highest Degree Obtained/Field of Study)	Licensure or Certification (Credentials or Hours Obtained)

- **NOTE:** If a staff member is assigned to more than one program, list the percentage of time (based on a 40-hour work week) that the person is assigned to each program.
- **NOTE:** Please note the name of the facility designee trained to initiate civil involuntary detentions (for DMH contracted agencies only).
- Please attach a listing of all current board members and contact information including address and e-mail with the board president denoted.

# Certification Addendum V

## PREVENTION ONLY PROGRAMS

Please complete the addendum below if you are applying for Prevention Programs. (See example below.)

Information to be submitted	Explanation	
Organization information, marketing materials, etc.	Examples include: Program brochures, pamphlets, newsletters, resources directories, and other relevant materials; distributing audiovisual materials such as films, tapes, public service announcements and other relevant materials; functioning as information resource center or clearinghouse; arranging speakers and presentations; and operating as a designated access point for computerized information network; web site access information, if applicable. Examples of informational and technical materials that are utilized by the program to provide services to the community. Documentation that the board reviews the program's materials.	
Activity logs (Please send examples of what is already on file; summaries or other reports should not be created for the review.)	Activities and Examples of what services have been provided. Examples of how program is comprehensive, research-based and culturally sensitive and relevant. Documentation of what populations are served. Examples of services being provided to coalitions.	
Training logs (Please send examples of what is already on file; summaries or other reports should not be created for the review.)	Documentation of what trainings have been provided to community groups and coalitions.	
Other Information (Please send examples of what is already on file; summaries or other reports should not be created for the review.)	Attach a description of significant developments, accomplishments, problems, or other issues of which the Department should be aware of since the last review.	

# Certification Addendum VI

## SUBSTANCE ABUSE TRAFFIC OFFENDERS PROGRAM (SATOP)

Please complete this addendum if you are applying for SATOP Programs. (See below.)

- 1) The following SATOP fee structure varies according to the number of clients served by your agency during the prior survey year. Please make sure your money order or check payable to the Department of Mental Health and mail with a copy of the application to the Controller's Office, PO Box 596, Jefferson City, MO 65120-0596.
  - a. The fee is \$125 if total clients served < 250
  - b. The fee is \$250 if total clients served 250-499
  - c. The fee is \$500 if served > 500 clients
  
- 2) For each program curriculum, please include the following:
  - a. Schedule of class times to include the following:
    - i. Days of the week class held
    - ii. Starting time/Ending time
    - iii. Break times
  - b. List of videos used with curriculum, if applicable
    - i. Length and title for each video
  - c. List of guest speakers (if applicable) to include the following:
    - i. Topic and length of presentation
  
- 3) Provide a copy of your agency's current Certificate of Good Standing from the Secretary of State's office.

# Certification Addendum VII

## REQUIRED DOCUMENTATION FOR AGENCIES APPLYING FOR CERTIFICATION

Please submit the following with this application:

### Policy and Procedures

- Initial Certification – Please submit copy of agency’s policy and procedure manual.
- Renewal Certification – Please send copy of new or revised policies and procedures developed since that last certification visit, as well as, medication policies and procedures.

### Building, Fire and Safety Inspection

- Initial Certification – Please submit copy of Fire, HVAC, Electrical, Plumbing, and Water inspections (if applicable).
- Renewal Certification – Please have the Fire and Safety inspections completed for all sites and submit verification with application.

### Governing Authority

- Please submit copy of the following:
  - Certificate of good standing
  - All board meeting minutes for the past 12 months
  - By-laws for your agency

### Quality Assurance

- Please submit a copy of the following:
  - Quality Assurance Plan
  - Quarterly and annual reports
  - Performance improvement projects and/or reports

### Fiscal

- Please submit copy of the following:
  - Annual budget by revenue (source and expenses)
  - Fiscal reports comparing budget experience
  - Fee schedules

### Insurance

- Please submit copies of all applicable insurance policies cover pages with effective dates indicated

### Dietary

- Please submit a copy of the following (if providing dietary services):
  - Menus for the last three months
  - Dietician credentials
  - Dietician reports
  - Policies that provide for special dietary needs
  - Local Health Department/Department of Health Annual Inspection

### Medications

- Please submit list of staff who has access to medications (if applicable)

### Orientation Packets

- Please submit a copy of informational materials given to consumers

### Program Schedules

- Please submit program schedules for all sites