CIMOR Organization Information Change Request Instructions

Complete one form for EACH Organization address requiring updates. If an entire site is moving and ALL services will be offered at the new location, one form will be accepted for the location change.

This form WILL NOT be accepted to request contract or certification changes. Those requests must be made directly to the appropriate ADA/CPS unit.

Definitions:
Organization - Provider or Agency Name
Primary Address - Physical location of the site
Executive Director - Chief Executive Officer, President or SATOP Administrator

SECTION 1: **ALL FIELDS IN THIS SECTION ARE REQUIRED FOR ALL REQUESTS**
Summary of Request- Include a detailed description of the changes being requested on this form.

SECTION 2: Complete **ONLY** if changes are to be made to the Organization Name and/or the Executive Director
Previous Organization Name - The former name of the organization as it currently appears in CIMOR
New Organization Name - The organization name as you want it to newly read in CIMOR
Previous Executive Director - The name of the former CEO/President/SATOP Administrator as it currently appears in CIMOR
New Executive Director - The name of the new CEO/President/SATOP Administrator as you want it to appear in CIMOR. Please include the Executive Director's title.

SECTION 3: **All Fields are Required when adding new locations or requesting changes to Physical/Primary, Billing and/or Mailing Address.**
Administrative Site - Check this box if this site is the administrative site for this organization
Add - Check this box if you are requesting this address be added to CIMOR and this is **NOT** a site that is moving.
Change - Check this box if you are requesting changes to an existing site's information
Delete - Check this box if you are requesting that this site be closed in CIMOR and no services will be provided as of the Effective Date on the last page of this request.
Previous Address - If the 'Change' or 'Delete' box is checked for any address type, complete this field to identify the address that needs to be changed or deleted.
New Address - If 'Add' or 'Change' box is checked for any address type, complete **ALL** of the New Address fields
Primary Address - Complete this section if Physical location/Phone Number/Fax Number/Contact Person has changed for an existing site of if requesting a new site.
Billing Address - Complete this section if the location is new or the current billing address requires changes.
Mailing Address - Complete this section if the location is new or the current mailing address requires changes.

NOTE: A new location cannot be added to CIMOR without a Telephone number.

SECTION 4: Complete Add/Delete Drop Down Boxes **ONLY** if changes are required or this is a request for a new location.
Add - Select 'Add' for new programs **and** levels that will be offered at the specified location as of the Effective Date
Delete - Select 'Delete' for programs **and** levels that will no longer be provided at the specified location as of the Effective Date.

Completed By, Effective Date and Phone Number are required for all requests.
Completed By - Digital signature of the person who completed the Organization Change Form
Effective Date - Date that the changes will be implemented
Phone Number - The contact number of the Person who digitally signed the 'Completed By' box.

Regional Representative Digital Signature and Date are required for all requests.

Email the completed form with digital signature to the appropriate regional representative:

EASTERN REGION: Howard Ross
Email: Howard.Ross@dmh.mo.gov **Phone:** (314) 877-0389
CENTRAL REGION: Kathleen Mims
Email: Kathleen.Mims@dmh.mo.gov **Phone:** (573) 751-9212
NORTHWEST REGION: Greg Apperson
Email: Greg.Apperson@dmh.mo.gov **Phone:** (417) 895-6328
SOUTHWEST REGION: Greg Apperson
Email: Greg.Apperson@dmh.mo.gov **Phone:** (417) 895-6328
SOUTHEAST REGION: Tom Kimbro
Email: Tom.Kimbro@dmh.mo.gov **Phone:** (573) 368-2298

For questions about this form, please contact your Regional Office at the numbers above.

DEPARTMENT OF MENTAL HEALTH
CIMOR ORGANIZATION INFORMATION CHANGE REQUEST

SECTION 1: Identification and Reason(s) for Request (REQUIRED FOR ALL REQUESTS)

Organization Name

Summary of Request (provide a detailed summary of your request and the reason for the request)

SECTION 2: Organization Name & Executive Director (Complete ONLY if changes are required)

Previous Organization Name

New Organization Name

Previous Executive Director

NAME TITLE

New Executive Director

NAME TITLE

SECTION 3: Address/Phone/Contact Person (REQUIRED for new locations and Address/Phone Changes)

Primary Address (Physical Location of Site) ☐ Administrative Site

PREV ADDRESS CITY / ST / ZIP

NEW ADDRESS

CITY STATE ZIP

COUNTY CONTACT / TITLE

SITE PHONE SITE FAX

EMAIL

Billing Address ☐ Same as Primary

PREV ADDRESS CITY / ST / ZIP

NEW ADDRESS

CITY STATE ZIP

Mailing Address ☐ Same as Primary

PREV ADDRESS CITY / ST / ZIP

NEW ADDRESS

CITY STATE ZIP

SECTION 4: Select ADD or DELETE on appropriate Services & Levels and list contract number in box at right.

COMPULSIVE GAMBLING

Compulsive Gambling

CSTAR

Adolescent

Residential Level 1 Level 2 Level 3

General Population

Residential Level 1 Level 2 Level 3

General Population Enh

Residential Level 1 Level 2 Level 3

Women & Children

Residential Level 1 Level 2 Level 3

Women & Children Enh

Residential Level 1 Level 2 Level 3

Women & Children Alt Care

Level 1 Level 2 Level 3

Detox Program

Modified Medical Social Setting

Opioid

GENERAL TREATMENT

Primary Recovery Plus

Detox - Social Setting

Residential Level 1 Level 2 Level 3

ATR Treatment

General Treatment

SUBSTANCE ABUSE TRAFFIC OFFENDERS PROGRAM (SATOP)

Offender Management Unit (OMU)

Offender Education Program (OEP)

Adolescent Diversion Education Program (ADEP)

Weekend Intervention Program (WIP)

Clinical Intervention Program (CIP)

Youth Clinical Intervention Program (YCIP)

Serious or Repeat Offender / Level IV

Required Educational Assessment and Community Treatment (REACT)

SUPPORT SERVICES

Recovery Support Access

Recovery Support

Transitional Housing

PREVENTION

Targeted

Primary

Statewide Resource Center

DEPARTMENT OF CORRECTIONS

Free and Clean Plus

Phase 1 Phase 2 Phase 3

Partnership for Community Restoration

Phase 1 Phase 2 Phase 3

STL Education

Case Management

CERTIFIED NON-CONTRACTED SERVICES

Detoxification - Medical

Detoxification - Modified Medical

Detoxification - Social Setting

Residential

Institutional Corrections

Outpatient - Community-based Primary Treatment

Outpatient - Intensive Outpatient Rehabilitation

Outpatient - Supported Recovery

Opioid

EFFECTIVE DATE:

PHONE NUMBER:

COMPLETED BY (Digital Signature):

REGIONAL REPRESENTATIVE (Digital Signature):