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 out completed application, print required attachments, scan into one PDF document and email the PDF to: dbhcertification@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—ACCREDITED AGENCIES

NAME OF ORGANIZATION (NAME ON CERTIFICATE OF GOOD STANDING) | TELEPHONE NUMBER | FAX NUMBER

ORGANIZATION TYPE
☐ FOR PROFIT ☐ NOT FOR PROFIT

NAME OF CHIEF ADMINISTRATIVE OFFICER | EMAIL ADDRESS | AGENCY WEBSITE ADDRESS

ORGANIZATION ADDRESS (ADMINISTRATIVE SITE) | CITY | STATE/ZIP CODE | COUNTY

ORGANIZATION MAILING ADDRESS | CITY | STATE/ZIP CODE | EMPLOYER TAX ID NUMBER

CONTACT PERSON FOR ORGANIZATION | TITLE | EMAIL | TELEPHONE

GOVERNING BODY PRESIDENT (REQUIRED) | STREET ADDRESS | CITY | STATE/ZIP CODE

GOVERNING BODY PRESIDENT EMAIL | NAME OF CORPORATE OWNER (IF APPLICABLE) | STREET ADDRESS

CITY | STATE/ZIP CODE

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.

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
- ☐ RESIDENTAL 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*.)

Site/Program Name	Street, City, Zip, County	Services Offered at Site	Contact Person for Site	Telephone & Fax Number	Days/Hours of Operation	Number of Residential Beds

Certification Addendum III

DESCRIPTION OF PROGRAM

Please 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

REQUIRED DOCUMENTATION FOR ACCREDITED AGENCIES

Agencies accredited by The Joint Commission, CARF, or COA must send a copy of the accreditation report with their application for certification. The report must include the effective dates of accreditation, type of standards used (only standards applying to Behavioral Health programs are acceptable for reciprocity), and type(s) of programs or services accredited.

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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 guess 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.