



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.

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/TITLE	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 CURRENTLY EMPLOYED BY YOUR AGENCY BEEN CONVICTED OR PLED GUILTY TO 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
 - PSYCHOSOCIAL REHABILITATION – ADULT CAPACITY
- COMMUNITY PSYCHIATRIC REHABILITATION PROGRAM – CHILDREN AND YOUTH
 - PSYCHOSOCIAL REHABILITATION – CHILDREN AND YOUTH CAPACITY
- OUTPATIENT MENTAL HEALTH
 - ADULT
 - CHILDREN AND YOUTH
- ACCESS CRISIS INTERVENTION
- HEALTH CARE HOMES – RENEWAL DESIGNATION
 - ADULT
 - CHILDREN AND YOUTH

SUBSTANCE USE DISORDER 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
 - ADULT CAPACITY
 - ADOLESCENT CAPACITY
- OUTPATIENT – COMMUNITY – BASED PRIMARY TREATMENT – LEVEL I (**minimum of 25 hours of services per week**)
 - ADULT
 - ADOLESCENT
 - With Residential Support Adult Capacity Adolescent Capacity
 - Without Residential Support
- OUTPATIENT – INTENSIVE OUTPATIENT REHABILITATION – LEVEL II (**minimum of 10 hours of services per week**)
 - ADULT
 - ADOLESCENT
- OUTPATIENT – SUPPORTED RECOVERY – Level III (**must offer a minimum of three hours per week**)
 - ADULT
 - ADOLESCENT
- 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
- RECOVERY SUPPORT SERVICES
- RECOVERY SUPPORT HOUSING (**attach NARR approval**)

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

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 and 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 Use Treatment programs, include Level of care provided at each site)</small>	Contact Person for Site	Telephone, Fax Number, Email	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 as Indicated on Page 2	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 this addendum 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.	
<p style="text-align: center;">Activity Logs</p> <p>(Please send examples of what is already on file; summaries or other reports should not be created for the review.)</p>	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.	
<p style="text-align: center;">Training Logs</p> <p>(Please send examples of what is already on file; summaries or other reports should not be created for the review.)</p>	Documentation of what trainings have been provided to community groups and coalitions.	
<p style="text-align: center;">Other Information</p> <p>(Please send examples of what is already on file; summaries or other reports should not be created for the review.)</p>	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: see **Policy and Procedure checklist** in the certification resource link.

- Initial Certification - Please submit copy of agency's policies and procedures identified on the Policy and Procedure checklist.
- Renewal Certification – Please send copy of new or revised policies and procedures since the last certification

Building, Fire and Safety Inspection

- Initial Certification - Please submit copy of Fire, HVAC , Electrical, Plumbing and Water
- Renewal Certification - Please have the fire and safety inspections completed for all sites and submit verification with the certification application

Governing Authority

- Please submit copy of Certificate of good standing with Missouri Secretary of State
- Please submit copy of all board meeting minutes for the past 12 months
- Initial Certification only - Please submit copy of By-Laws for your agency.
- Renewal Certification - send copy of any updated Bylaws.

Quality Assurance

- Please submit copy of Quality Assurance Plan
- Please submit copy of quarterly and annual reports
- Please submit performance improvement projects and/or reports

Fiscal

- Please submit annual budget by revenue (source and expenses)
- Please submit fiscal reports comparing budget experience
- Please submit Fee schedule

Insurance

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

Dietary (if applicable)

- Please submit menus for the last three months
- Please submit dietician credentials
- Please submit dietician reports
- Please submit policies that provide for special dietary needs
- Please submit applicable health inspections

Medication

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

Medication Assisted Treatment (MAT)

- Please submit a policy/procedure on Medication Assisted Treatment (MAT). (for organizations requesting certification for substance use disorders.)
- Please submit screening tool for MAT (examples MAST).
- Please submit *Memorandum of Understanding (MOU) with another agency or Doctor that will offer MAT, if your agency does not offer MAT.

Certification Addendum VII (cont'd)

Crisis Assistance and Intervention

- Please submit policy on crisis assistance and intervention.
 - The organization should provide or arrange 24 hour per day, seven days a week crisis assistance that is provided by qualified staff that includes face-to-face interaction when clinically indicated.
 - The agency should have at least two persons, available on staff, to provide crisis assistance and intervention if the crisis service is provided by your organization.
 - If the agency does not provide crisis assistance or intervention internally, please submit MOU with agency that will provide crisis intervention that describes how communication between agencies will occur.

Orientation Packets

- Please submit a copy of informational materials given to consumers, including orientation packets specifically for parents/caregiver.

Program Schedules

- Please submit program schedules for all sites include group schedule

Note: All agencies seeking treatment certification must have a **qualified licensed diagnostician who will render diagnosis.

Definitions:

* Memorandum of Understanding (MOU) - A document that expresses mutual accord on an issue between two or more parties.

Memoranda of understanding are generally recognized as binding, even if no legal claim could be based on the rights and obligations laid down in them.

**Qualified Diagnostician- licensed physician, licensed psychologist, licensed clinical social worker, and licensed professional counselor and provisionally licensed individuals or LMSW practicing within the scope of their profession and skills. Diagnostician must have at least one year experience in treating persons with substance use disorder.

Final Certification Checklist

Please note that incomplete applications will cause a delay in the application process and may result in a return of the application.

- Policy and Procedures: see Policy Procedure checklist available in the certification resources link.
- Building, Fire and Safety Inspection
- Governing Authority information
- Quality Assurance
- Fiscal information
- Insurance – all current liability insurance policies
- Dietary information – if applicable
- Medication – staff that have access to medication
- Medication Assisted Treatment for the treatment of addiction information or MOU
- Client Orientation Packets
- Program Schedule – Group Schedule
- Crisis assistance and Intervention information or MOU
- List of all personnel
- Agency Brochure – list all services provided with description of services.
- Table of Organization- include each person filling each position, lines of supervision, include vacancies
- List of all Personnel -- full time, part time, volunteers, administrative, practicum/ intern students, contracted staff, maintenance
- If staff is assigned to more than one program identify the percentage of time in each program.
- Note designee trained to initiate Civil involuntary detention (if applies)
- A list of current sites – program name, physical address, services offered, contact person, hours of operation, telephone and fax number
- Signed Acknowledgement Statement
- Licensing, Certifying or Accrediting Body reports and verification of current status.
- Explanation of the components/programs in your agency that you are not requesting certification.
- Explanation if any person listed on the application has been convicted of a felony. Send **DMH EXCEPTIONS LETTER** with application.

An agency personnel should insure that you have all documents accompany the application and sign below. It is recommended that a second person review the checklist to make sure all documents are attached.

1st Reviewer Signature

2nd Reviewer Signature