**APPLICATION FOR Certification Renewal**

**Alcohol/Drug Treatment Program**

*Complete one application per Program Location*

**Organization/Corporate Information *Please Print Legibly***

Legal Name of Organization/Corporation:

National Provider Identification (NPI) #

Organization/Corporation Office Address:

City:       State:       Zip:

Corporate Office Telephone:       Fax:

Executive Director of Alcohol and Drug Program:

Executive Director Mailing Address:

City:       State:       Zip:

Telephone:       Email:

**Board President Name** *if applicable***:**

Telephone:       Email:

**Website:**

**Program Location Information *Please Print Legibly***

Program Name:

Program’s Street Address:

City:       State:       Zip:

Program’s Telephone:       Fax:

Name of Program Director:

***The Program Director receives site visit summaries, scheduling letters & mass emails from the State in email format.***

His/Her Mailing Address:

City:       State:       Zip:

Telephone:       Email:

**Program Information**

Program Hours of Operation: A.M.       P.M.

Other: (please specify)

**Funding Sources** (check all that apply): Medicaid [ ]  AAPS [ ]

SB123 [ ]  4th Time DUI [ ]  Private Pay [ ]

**Special program type**:

 [ ]  Faith Based [ ] SB 123 (program is receiving funds from DOC)

[ ]  DUI Evaluations: Please complete the additional DUI Evaluator Packet

**Populations Served:**

*Please check all that apply*

[ ]  Adolescents

[ ]  Adult Men

[ ]  Seniors or Older Adults

[ ]  Women w/ Children

[ ]  Adult Women

[ ]  Pregnant or Postpartum Women

[ ]  Co-Occurring

[ ]  Persons with HIV or AIDs

[ ]  Hearing Impaired

[ ]  Native American

[ ]  Gays or Lesbians

[ ]  Criminal Justice

**Languages Available:**

*Please check all that apply for this program*

[ ]  Spanish

[ ]  Korean

[ ]  Vietnamese

[ ]  American Sign Language (ASL)

[ ]  Other: (Please specify)

**Program Services Provided and number of beds, if applicable**.

Number of Beds

[ ]  Acute Detox

[ ]  Inpatient

[ ]  Social Detoxification

[ ]  Therapeutic Community

[ ]  Intermediate

[ ]  Reintegration

Total Number of Beds:

[ ]  Outpatient: Intensive

[ ]  Outpatient: Counseling Treatment

[ ]  Early Intervention/Interim Services

[ ]  Opioid Maintenance Treatment: **MEDICAL DIRECTOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Alcohol & Drug Assessment & Referral Program *(****Required by all programs****)*

**Required Signatures:**

 Name/Title of person completing this application Date

 Executive Director of Alcohol & Drug program Date

**Materials Required for Certification**

***\*\*****If your program is in good standing with a National Behavioral Accreditation Body or has a Mental Health License; Please submit this request to BHS in addition to the following for Certification:*

**[ ]  Application**

**[ ]  Application Fee** (enclose a fee of $100.00 per Program Location. Make checks payable

 to: The Department for Aging & Disability Services/Survey Certification & Credentialing.)

**[ ]**  **Complete list of employees, job titles and BSRB credentials (if applicable)**

[ ]  **A copy of the current accreditation certificate or Mental Health license**

[ ]  **A copy of the accreditation body or Mental Health survey findings** (If renewed in the past certification cycle)

**[ ]  A copy of corrective action plans submitted to the accreditation body or Mental Health,** (If renewed in the past certification cycle)

**[ ]  Any follow up responses from the last on-site survey.** (If renewed in the past certification cycle)

[ ]  **If completing DUI Evaluations- Completed DUI Evaluator packet**

Please return the completed application with all required materials to:

*Stephanie.Simpson@ks.gov* ***Or***

KDADS/ Survey Certification & Credentialing / *Attention: Stephanie Simpson*

612 S. Kansas Avenue, Topeka, KS 66603