ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER CERTIFICATION BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be completed upon initial application for DBHS RSPMI Certification.

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent):_____

Administrative Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission on Accreditation of Healthcare Organizations (J-CO)
____ Commission on Accreditation for Rehabilitation Facilities (CARF)
____ Council on Accreditation (COA)

Date(s) of most recent survey: _____

Accreditation Period: _____ through _____

The accredited provider is located within the State of Arkansas.

_____ Yes _____ No

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Qualification Form for RSPMI Provider Certification

All of the following information must be attached to the Qualification Form for RSPMI Certification (DBHS Form 1). Applications must be submitted in full.

1. Latest accreditation survey results. (The entire survey report covering outpatient mental health services must be included.)

2. Copies of all correspondence and e mails (e mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient mental health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery. (See DBHS Form 1 Attachment #1)

4. All Evidence of Compliance, Measures of Success, Performance Improvement Plans, and any Corrective Action Plans submitted to the accreditation organization pertaining to outpatient mental health services.

5. Annual RSPMI Services and Resource Summary Report with all attachments as designated in the RSPMI Services and Resource Summary Form (DBHS Form 2).

DBHS WILL SCHEDULE AN ONSITE SURVEY WITHIN TWENTY (20) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164

Please send a cover letter and all application materials to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF POLICY AND CERTIFICATION

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Division of Behavioral Health Services, Policy and Certification Office, for the specific purpose of obtaining or sharing information relevant to RSPMI Provider Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

_____ _____
Signature of CEO (or equivalent) Date

_____ _____
Signature of Witness Date