

**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: _____

Corporate Compliance Officer (or equivalent): _____

Address: _____ **FAX:** _____

_____ **E-mail:** _____

_____ **Website:** _____

County: _____

Telephone: _____

1. 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 (JCAHO)

_____ Commission on Accreditation for Rehabilitation Facilities (CARF)

_____ Council on Accreditation (COA)

2. Date of most recent survey: _____

3. Certification Period: _____ through _____

4. The accredited provider is located within the State of Arkansas.

_____ Yes

_____ No

As the chief executive officer (or equivalent position) 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

Date

Name of CEO, typed or printed

Page Two
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. Partial submissions will not be accepted.

1. Latest accreditation survey results. (The entire survey report covering outpatient mental health services must be included.)
2. Copies of all correspondence 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.
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 (Form 2).

DBHS WILL SCHEDULE AN ONSITE SURVEY WITHIN FORTY-FIVE (45) CALENDAR DAYS OF RECEIVING AND APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

If you have any questions, please contact Charlotte Carlson, Director of Policy and Certification, Division of Behavioral Health Services at (501) 683-6903 or e-mail: charlotte.carlson@arkansas.gov .

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

Attn. Charlotte Carlson
Division of Behavioral Health Services
305 South Palm
Little Rock, AR 72205