

Ohio Department of Mental Health and Addiction Services

Application for Certification for Supplemental Behavioral Health Services

For Use Only by a Currently Certified Provider

Instructions: Please fill out the information on this form, and mail it to the address below, with the attached supporting documentation. Do not submit this document without all of the required documentation, including a letter of support from the ADAMH/MHRS Board that is or will be funding the service. *Incomplete submissions will be returned.*

Certification Number (MH or SUD): _____

Provider Name: _____

Mailing Address (street): _____

Mailing Address (city, zip): _____

Contact Person Name and Title: _____

Contact Person e-mail: _____ Contact Person Phone: _____

Is your agency requesting certification for Supplemental Behavioral Health Services to replace a currently certified service for which there will be no corresponding certification effective January 1, 2018? YES _____ No _____

Please attach the following documentation:

1. Name of Service
2. Description of Service
3. Letter of Approval from a Board

Mail to:

OhioMHAS
Licensure and Certification
30 East Broad Street, Suite 742
Columbus OH 43215