South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

Office of
Licensing and Accreditation

Renewal Application for
Prevention, Substance Use Disorder, and/or Mental Health Services

Section I: Contact Information

Agency Information:

Agency Name _____
Corporation Name _____
Address _____
Phone _____
Agency E-mail Address _____
Website Address _____
Business or Non-Profit _____
Federal Tax ID Number _____
National Provider Identification _____

Executive Director Information

First & Last Name _____
E-mail Address _____
Address: If different than above. _____

Alternate Contact

First & Last Name _____
E-mail Address _____
Address: If different than above. _____

Satellite Office Information (If applicable)

Name of Satellite Office _____
Address _____
Website Address _____
Contact Name _____
E-mail Address _____
Building Leased or Owned _____

List the services provided at this satellite location:

Additional Satellite Office Information (If applicable)

Name of Satellite Office _____
Address _____
Website Address _____
Contact Name _____
E-mail Address _____
Building Leased or Owned _____

List the services provided at this satellite location:

Section II: Policies and Procedures Contact

The agency will be required to submit all policies and procedures 30 days prior to the accreditation review. Once the agencies application has been approved, directions will be sent on how to submit your policies and procedures. Indicate below who will be the contact to work with to obtain the agency policies and procedures.

First & Last Name _____
Title or Role _____
E-mail Address _____

Alternate Contact:
First & Last Name _____
Title or Role _____
E-mail Address _____

Section III: Program Classification

Indicate the level(s) of care for which you are seeking accreditation by placing an "x" if the service is provided to adults or youth. If you provide services to both, place an "x" in both boxes. Identify the number of clients that you have the capacity to serve for each of the services you provide, as well as the number of clinical staff that provide services to the clients.

Prevention Services	Adult	Youth	Client Capacity	# of Staff
All Prevention Services				

Substance Abuse Services	Adult	Youth	Client Capacity	# of Clinical Staff
Outpatient Services				
.05 Early Intervention				
1.0 Outpatient Treatment				
2.1 Intensive Outpatient Treatment				
Day Treatment				
2.5 Day Treatment				
2.5 Day Treatment with Residential Services				
Residential Treatment				
3.1 Clinically Managed Low-Intensity Residential Treatment				
3.2D Clinically Managed Residential Detoxification				
3.7 Medically Monitored Intensive Inpatient Treatment				

Mental Health Services	Adult	Youth	Client Capacity	# of Clinical Staff
Outpatient Mental Health				
Children Youth and Family				
Comprehensive Assistance with Recovery and Empowerment (CARE)				
Individualized Mobile Programs of Assertive Community Treatment (IMPACT)				

Additional Services:

In addition to what is listed above, what other services or programs does your organization provide?

Additional Licensure, Certification or Accreditation (If applicable)
Identify other licensures, certifications, or accreditations.

Prevention Agencies Curriculum:
What curriculum or programs does your organization provide?

Section IV: Confirmation

The applicant hereby agrees to provide access to the agency's premises, records and personnel to authorized representatives of the Department of Social Services for the purpose of determining compliance with standards or to investigate complaints brought against the applicant.

Executive Director Name (type or print): Date:

Executive Director Signature:

If you are submitting this form electronically, please type name above and check this box ☐ to confirm that this emailed document is a binding agreement without the actual signature of the Executive Director. Please email to DSSLicAccred@state.sd.us

OR, you may print this page, sign, and fax to (605) 367-5239

Mail to:
Office of Licensing and Accreditation
3900 W Technology Cir. Suite 1
Sioux Falls, SD 57106

_____ _____
Authorized Signature Date

_____
Title or Position of Individual Signing

If you have questions about accreditation or the application process, please contact Muriel Nelson at muriel.nelson@state.sd.us or DSSLicAccred@state.sd.us.