SD DIVISION OF BEHAVIORAL HEALTH
SUBSTANCE ABUSE ACCREDITATION APPLICATION

SECTION I – GOVERNANCE

Agency Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone #: _____
Fax #: _____
E-Mail Address: _____

Director: _____
Address (if different from Agency): _____
City: _____ State: _____ Zip: _____
Fax # (if different from Agency): _____
Telephone # (if different from Agency): _____
E-Mail Address: _____

Designated Alternate to the Director: _____

Address (if different from Agency): _____
City: _____ State: _____ Zip: _____
Telephone # (if different from Agency): _____
Fax # (if different from Agency): _____
E-Mail Address: _____

Corporation Name of Applicant: _____
Federal Tax ID #: _____
National Provider Identification (NPI): _____

Is the Agency incorporated as a ◯ Business or ◯ Non-Profit - if applicable.

If making application for a Non-Corporation, please identify the lines of authority:

Corporate Applicants – List Board of Directors (names, occupations and identify office holders:

SECTION II – ACCREDITATION OF REQUEST BY PROGRAM CLASSIFICATION

Indicate each program classification for which the applicant agency is seeking accreditation. On separate sheets, provide a description of those services and activities to be provided relative to each program classification for which accreditation is being sought and listing of agency staffing requirements. Include the agency's admission, continued service and discharge criteria.

Program Classification	Client Capacity	Number of Personnel (Full-time Equivalents) Assigned or Planned
Clinically-Managed Residential Detoxification	_____	_____
Early Intervention Services	_____	_____
Intensive Outpatient Treatment	_____	_____
Level III.7 Medically Monitored Intensive Inpatient Treatment for Adolescents	_____	_____
Level III.7 Medically Monitored Intensive Inpatient Treatment for Adults	_____	_____
Level III Clinically Managed Low-Intensity Residential Treatment	_____	_____
Level II.5 Day Treatment Services for Adolescents and Adults	_____	_____
Outpatient Services	_____	_____
Gambling Treatment	_____	_____
Prevention	_____	_____

*Provide the number of clients your organization could provide services to at any one point in time. For prevention, give the size of the target population on which you hope to have an impact.

SECTION III – DOCUMENTATION OF A COMMUNITY NEEDS AND RESOURCE ASSESSMENT
(For first time applicants or an agency adding a new level of service)

Provide documentation of a community needs and assessment presenting evidence of need or demand for the services to be provided. The need and resource assessment shall contain:

(a) A definition of the community where services will be provided;
(b) The prevalence and type of substance use occurring in the community to include local trends in use compared to national and state alcohol and other drug prevalence rates and social indicator data for the target population to be served;
(c) Documentation that demonstrates that an adequate demand for the services exists and information about the target population and age group for which the service will be provided;
(d) A list of existing community resources to include names and addresses of competing agencies. Include a statement of comparison, strengths and weaknesses that will enable the

agency to compete effectively with other agencies providing similar services. Describe advantages of services to be provided over those of competing agencies; and

(e) Letters of support from community members, agencies and referral sources.

SECTION IV – ORGANIZATION, RISK ASSESSMENT, PERSONNEL AND CLIENT GUIDELINES

Provide a list of current personnel indicating position held, qualifications, certification status with expiration date of credentials for chemical dependency counselor position and other health care licenses or certificates related to job duties.

Provide an organization chart that reflects the agency's staffing requirements and lines of authority.

Provide a copy of the agencies most recent TB risk assessment.

Provide a copy of the agency's client handbook including rules and discipline procedures (Not applicable for prevention programs).

Provide a copy of the agency's client's attendance policy (Not applicable for prevention programs).

SECTION V – BUDGET, AUDIT, ARTICLES OR INCORPORATION, CORPORATE FILING, PROGRAMS FEES, SLIDING FEE STRUCTURE AND INSURANCE COVERAGE

Provide a business plan to include an executive summary, operations, marketing and financial management.

Provide a copy of the agency's annual report for the current fiscal year showing anticipated revenues and expenditures. The annual report should be an overview of the agency and include a summation of the services provided, program changes and goals accomplished.

Provide a copy of the agency's alcohol and drug activities budget to include a cash flow sheet, income statement and a balance sheet. Anticipated revenues must be shown by source and expenditures must be shown by category. Agencies which are newly formed shall submit a report to include start up costs, operating costs, sources of financial income, revenue projections and a monthly operating budget for the first year.

Existing agencies shall provide a copy of an annual entity-wide, independent financial audit and cost report. The audit shall be conducted in accordance with the Federal Office of Management and budget (OMB) Circular A-133 by an auditor approved by the Auditor General to perform the audit.

Provide a copy of the agency's Articles of Incorporation if required and the last corporate report filing required by the Secretary of State.

Provide a copy of current program fees and sliding fee schedule.

Provide documentation of insurance coverage, including bonding, sufficient to cover all client funds, property and interests.

SECTION VI – SDCL 34-12 REPORTS

For programs that are subject to the provisions of SDCL chapter 34-12, provide a copy of the agency's current license issued by the Department of Health, current environmental and safety reports, National Fire Prevention Association (NFPA) Life Safety Code inspection reports and written policies for dietetic services and medication control.

SECTION VII – FEES

A fee of $150.00 has been fixed for the required inspections for the accreditation process. Applicants that are a component of state government are exempt from this requirement. A check or money order in the amount of the fee, made payable to the South Dakota Department of Social Services must accompany this application.

SECTION VIII – APPLICANT REPRESENTATION

The applicant hereby signifies its intention and ability to comply with all applicable provisions of SDCL 34-12 and 34-20A and all rules adopted there under. The applicant gives assurances that it is in compliance with all applicable ordinances of the political subdivisions in which it is located. The applicant hereby agrees to provide access to the agency's premises, records and personnel to authorize representatives of the Department of Social Services for the purposes of determining compliance with standards or to investigate complaints brought against the applicant.

_____ _____

Authorized Signature Date

Title or Position of Individual Signing for the Applicant Agency

*****AGENCIES MUST SUPPLY ALL INFORMATION REQUESTED ON THE APPLICATION. AN INCOMPLETE APPLICATION WILL BE RETURNED TO THE APPLICANT AND WILL NOT BE CONSIDERED UNTIL PROPERLY COMPLETED.**