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.

<table>
<thead>
<tr>
<th>Prevention Services</th>
<th>Adult</th>
<th>Youth</th>
<th>Client Capacity</th>
<th># of Staff</th>
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</thead>
<tbody>
<tr>
<td>All Prevention Services</td>
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<table>
<thead>
<tr>
<th>Substance Abuse Services</th>
<th>Adult</th>
<th>Youth</th>
<th>Client Capacity</th>
<th># of Clinical Staff</th>
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<tbody>
<tr>
<td>Outpatient Services</td>
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<tr>
<td>.05 Early Intervention</td>
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<tr>
<td>1.0 Outpatient Treatment</td>
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<tr>
<td>2.1 Intensive Outpatient Treatment</td>
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<tr>
<td>Day Treatment</td>
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<tr>
<td>2.5 Day Treatment</td>
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<tr>
<td>2.5 Day Treatment with Residential Services</td>
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<tr>
<td>Residential Treatment</td>
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<tr>
<td>3.1 Clinically Managed Low-Intensity Residential Treatment</td>
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<td>3.2D Clinically Managed Residential Detoxification</td>
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<td>3.7 Medically Monitored Intensive Inpatient Treatment</td>
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<tr>
<th>Mental Health Services</th>
<th>Adult</th>
<th>Youth</th>
<th>Client Capacity</th>
<th># of Clinical Staff</th>
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</thead>
<tbody>
<tr>
<td>Outpatient Mental Health</td>
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<tr>
<td>Children Youth and Family</td>
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<td>Comprehensive Assistance with Recovery and Empowerment (CARE)</td>
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<td>Individualized Mobile Programs of Assertive Community Treatment (IMPACT)</td>
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### Additional Services:

In addition to what is listed above, what other services or programs does your organization provide?
Renewal Application for Prevention, Substance Use Disorder, and/or Mental Health Center Provider

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.