ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Provider Services & Quality Assurance

APPLICATION FOR CERTIFICATION

PARTIAL HOSPITALIZATION

☐ NEW ☐ AMENDING

APPLICANT INFORMATION

PROGRAM NAME: _____

PHYSICAL ADDRESS: _____
Street *City* *County* *State* *Zip Code*

MAILING ADDRESS: _____
(if different) *Street* *City* *County* *State* *Zip Code*

E-MAIL ADDRESS: _____

PHONE NUMBER: _____

TAXPAYER ID # (TIN): _____ BEHAVIORAL HEALTH AGENCY CERTIFICATION NUMBER: _____

OPERATOR INFORMATION

DIRECTOR NAME: _____

OWNERSHIP TYPE: ☐ SOLE-PROPRIETORSHIP ☐ PARTNERSHIP ☐ CORPORATION

☐ PRIVATE ☐ NON-PROFIT ☐ OTHER (specify): _____

The applicant affirms receipt of the *Partial Hospitalization Certification Manual* standards and agrees to comply with these standards, as indicated by the signature below:

_____
Signature of Applicant Date

Please see requirements on page 2 that must accompany applications. Submit applications to DPSQA.ProviderApplications@dhs.arkansas.gov.

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NEW APPLICANT

1. Name, address, and percentage of ownership for all owners with more than 5% of ownership interest
2. If applicable, list of Board of Directors including names of officers and mailing address

AMENDING APPLICANTS

Please include a type-written description of the physical address(es) seeking certification under this program. Please also include your current Partial Hospitalization certification number on your description.

*Additional information may be requested and required upon review of application(s) for certification.