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

APPLICATION FOR CERTIFICATION

THERAPEUTIC COMMUNITIES

☐ NEW ☐ AMENDING
☐ LEVEL I ☐ LEVEL II

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 *Therapeutic Communities 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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APPLICATION FOR CERTIFICATION

THERAPEUTIC COMMUNITIES

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 and denote whether the location(s) are being utilized for residential purposes. Please also include your current Therapeutic Communities certification number on your description.

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