Department of Health & Social Services
Division of Behavioral Health
Request for Department Approval Form

Provider Name: ______________________ Date of Request: __________

Address of Primary Location: ______________________

Executive Director: ______________________

Are you nationally accredited? ☐ Yes ☐ No If Yes, accrediting body: __________

Physical Location: ______________________ Service Area: __________

Service Categories: ☐ Clinic ☐ Rehabilitation ☐ Detoxification ☐ Residential Substance Use ☐ Day Treatment

Level __________ | __________

Physical Location: ______________________ Service Area: __________

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Level ____________ | ______________

I hereby certify that the information provided in this document is a complete and accurate representation of the services provided by this organization, including physical locations, service areas and service categories.

- ☐ By requesting a Department Approval, I acknowledge understanding of the regulations governing these services and certify this organization is in full compliance with regulations to lawfully provide these services.
- ☐ By requesting a Probationary Department Approval, I acknowledge understanding of the regulations governing these services and I am working to meet the interim standards in 7AAC 70.200-260.

I will notify the Department in writing, using an addendum to this form, if this organization wants to add service categories, locations, or service areas.

I affirm that these physical locations, service areas, and service categories will be included in any evaluation by a national accreditation body contracted by this organization.

______________________________ ______________________________

Executive Director Date