

**Oregon Health Authority  
Addictions and Mental Health Division  
New Provider Application to become certified as a  
Provider of Non-Inpatient Mental Health Services**

**Agency Contact Mailing Street City/State/Zip: \_\_\_\_\_ E-mail \_\_\_\_\_**

**Name: \_\_\_\_\_ Person/Director: \_\_\_\_\_ Address: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ address: \_\_\_\_\_**

**Other locations where services are provided: \_\_\_\_\_**

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Type of Certification requested: \_\_\_\_\_ Non-Inpatient (OAR 309-039-0550)  
 \_\_\_\_\_ Day Treatment or Partial Hospitalization (OAR 309-039-0560)  
 \_\_\_\_\_ Residential Program (OAR 309-039-0570)

*Make \$600.00 payable to Oregon Health Authority*

Program check off	All applicants complete one through seven	AMH check off
	1. Provide a detailed organizational chart which lists each clinician by name and degree, and identifies supervisory structure.	
	2. Provide a copy of the organization's policies and procedures demonstrating compliance with Oregon Administrative Rules 309-039-0500 through 309-039-0580.	
	3. Provide a description of the organization's practices for credentialing the clinical staff.	
	4. Provide Tax I.D.# and copy of business license. If not available, explain why.	
	5. Written description of clinical supervision practices including employment status of supervisors.	
	6. Written statement describing ownership and control of program clinical records.	
	7. Written description of how cases are assigned to clinicians by the program.	
<b>For applicants requesting certification for multiple locations, submit the following for each office location:</b>		
	8. Photo of program sign documenting that the name of the program is posted in a <u>CLEARLY VISIBLE</u> manner.	
	9. Photo of storage area and written description documenting how records are stored.	
	10. Facility floor plan, including designated sitting area, if applicable.	
	11. Written assurance that the facility has sufficient soundproofing to protect the confidentiality of client communications.	