**SERVICE AGENCY PROFILE**

\*IMPORTANT\*

This form is to be completed by the Community Mental Health Services Program (CMHSP) for each service agency which provides services to recipients as part of CMHSPs array of service. A service agency is the CMHSP itself, or contract agencies which provide services to recipients. A form must be completed for each service agency under contract with the CMHSP as well as the CMHSP.

This form must be resubmitted if there is a change in type of service provided at a site, or if services are provided at a site not listed on a previously submitted form, or if services are no longer provided at a previously reported site. It must be completed if a new service agency begins services as part of CMHSPs array of services.

1. General Information: *Click here to choose one.*

2. Desired Effective Date for Addition or Change: *Click to choose date.*

|  |  |
| --- | --- |
| 3. PIHP*Choose an item.* | 4. Service Agency Name*Click here to enter text.* |
| 5. Service Agency Address*Click here to enter text.* |
| 6. City*Click here to enter text.* | 7. Zip*Click here to enter text.* | 8. Telephone Number*Click here to enter text.* |
| 9. Service Agency Administrator Name*Click here to enter text.* | 10a. Accreditation Type *Click here to enter text.*10b. Expiration Date *Click here to enter a date.* |

**Service Agency Sites (for multiple locations of the provider listed in #3 above)**

**\* Services which require approval from DCH for enrollment**

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| 11. Program Name, Address, City, ZIP*Click here to enter text.*Telephone*Click here to enter number.* | 12. Services (click on and select either I, II, III, IV, or V)*I.**II.**III.**IV.**V.* |
| 11. Program Name, Address, City, ZIP*Click here to enter text.*Telephone*Click here to enter number.* | 12. Services (click on and select either I, II, III, IV, or V)*I.**II.**III.**IV.**V.* |
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