



2. Does your Organization currently have Certification/Accreditation from another organization?

Yes  No

If Yes, accreditation granted by: Check all that apply

Joint Commission on Accreditation of Health Care Organizations (JACHO),

Commission on Accreditation of Rehabilitation facilities (CARF)

National Committee for Quality Assurance (NCQA)

Council Quality Leadership (CQL)

Council for Accreditation (CAO)

Other \_\_\_\_\_

3. Budget of organization as stated in most recent IRS 990 filed. \_\_\_\_\_

4. What is the total number of staff employed in the Program(s) that you are seeking Accreditation? \_\_\_\_\_

a. Total number of Clinical staff (for definition see page 23) \_\_\_\_\_

b. Total Number of Specialists (for definition see page 23&24) \_\_\_\_\_

c. Total Number of Direct Support Professional Staff (DSP) (for definition see page 24) \_\_\_\_\_

**Information about Program(s) for which  
you Are Seeking Accreditation**

- e. Types of Programs for which you are seeking accreditation. (Note: NADD grants accreditation to programs that provide services to individuals with a dual diagnosis, not the agency or organization that offers these programs. An organization with several different programs that serve individuals with a dual diagnosis may seek accreditation for each of these programs. A single application fee covers as many programs as an organization seeks to have accredited.) (check all that apply)

Outpatient Mental Health

Medical Service

Behavior Consultation  
Service

Rehabilitation

Crisis Intervention

Community Housing

Residential Services

Education / School

Employment Planning and  
Customized Supports

Community or Mobile Team

Home / Community Supports

Host family/shared living

Living independently

Supports Coordination

Case Management/Service  
Coordination

Crisis Stabilization Unit/Program

Inpatient Hospital / Developmental Center

Other – Describe: \_\_\_\_\_

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**For each program for which you are seeking accreditation, please provide the following information:** (Use additional pages as necessary.)

Program name \_\_\_\_\_

Program address if different than principal organization address:

\_\_\_\_\_  
\_\_\_\_\_

Program Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ email: \_\_\_\_\_ fax \_\_\_\_\_

- f. How many people are served in the program for which you are seeking accreditation? \_\_\_\_\_
- g. How many people with a Dual Diagnosis (IDD/MI) are served in the program for which you are seeking accreditation? \_\_\_\_\_
- h. Check all of the age ranges of persons served with Dual Diagnosis (MI/ID) in your program. Please indicate the percentage of the Dual Diagnosis population in the program each age bracket represents.
- \_\_\_\_ Children/birth to 12 years \_\_\_\_\_%
- \_\_\_\_ Adolescent/young adult 12 – 21 years \_\_\_\_\_%
- \_\_\_\_ Adult 21– 55 years \_\_\_\_\_%
- \_\_\_\_ Older adults 55+ \_\_\_\_\_%
- i. Under the authority of which regulatory or licensing agency(ies) does the program for which you are seeking accreditation operate?
- \_\_\_\_ Mental Health (MH)
- \_\_\_\_ Intellectual Disability (ID)
- \_\_\_\_ Medical
- \_\_\_\_ Rehabilitation
- \_\_\_\_ Education

\_\_\_ other: \_\_\_\_\_

Please specify the name of the regulatory or licensing agency(ies):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

j. Provide a program description for each program for which you are seeking accreditation.

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Please include agency/program brochure(s) if available.

**Application should be mailed to:**

NADD Accreditation & Certification Programs  
12 Hurley Avenue  
Kingston, NY 12401

**Payment of the application fee:**

Check enclosed (Please make checks payable to : NADD.)

Please charge my credit card     MasterCard     VISA     Discover

Card Number: \_\_\_\_\_

Exp. Date: \_\_ \_\_ / \_\_ \_\_    Signature: \_\_\_\_\_