Application for Accreditation

Information about Organization

Name of Organization:____

Principal mailing address:____

____

____

Phone: ______________________________ Fax ___________________________

Email: ______________________________Website: ________________________

Name of CEO of Organization____

____

1. Please provide a description of your organization: ______________________

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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
___ Crisis Stabilization Unit/Program
___ Inpatient Hospital / Developmental Center
___ Employment Planning and Customized Supports
___ Community or Mobile Team
___ Home/Community Supports
___ Host Family/Shared Living
___ Living Independently
___ Supports Coordination
___ Case Management/Service Coordination

___ Other – Describe: ________________________________

____

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 Emailed to: accreditation@thenadd.org

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: ________________________________