NADD

An association for persons with developmental disabilities and mental health needs.

Application for Re-Accreditation

Name of Organization:_____

Principal mailing address:_____

_____

_____

Phone: _____ Fax _____

Email: _____Website: _____

Budget of organization as stated in most recent IRS 990 filed._____

CEO of Organization:_____

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

1. Program name _____

Program address if different than principal organization address:

_____

_____

_____

Program Contact:_____

Phone:_____ Email:_____

2. What is the total number of staff employed in the program for which you are seeking Re-accreditation? _____

   a. Total number of Clinical staff (as defined on page 23) _____
   b. Total Number of Specialists (as defined on pages 23&24) _____
   c. Total Number of Direct Support Professionals (DSP) (as defined on page 24) ____

3. How many people are served in the program for which you are seeking re-accreditation?

   _____

4. How many people with a Dual Diagnosis (IDD/MI) are currently served in the program for which you are seeking re-accreditation? _____

5. Check all of the age ranges of persons served with Dual Diagnosis (MI/ID) in your program.

   ____ Children - Birth to 12 years

   ____ Adolescent/Young adult 12 – 21 years

   ____ Adult 21– 55 years

   ____ Older adults 55+

6. Please specify the name of the regulatory or licensing agency(ies) under which this program operates:_____

   _____

Application should be emailed to: accreditation@thenadd.org