Application for Accreditation

Information about Organization

Name of Organization:____

*Principal mailing address:____

____

____

Phone: _____________________________ Email: _______________________

Website: ____

Name of CEO of Organization____

____

Please provide a description of your organization:

____

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____

1. Does Organization currently have Certification/Accreditation from any other organization(s)? __ 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 ____

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

3. Total number of staff employed by your organization. ____________________
4. Total number of programs for which you are seeking accreditation __________
5. 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)

__ Inpatient Hospital/Developmental Ctr
__ Outpatient Mental Health
__ Medical Service
__ Behavioral Service
__ Rehabilitation
__ Crisis Intervention
__ Partial Hospital
__ Residential Services
__ Education / School
__ Day Habilitation
__ Supported Employment
__ Mobile Team
__ In-Home Supports/Services
__ Supports Coordination/Case Mgmt
__ Family Based Service

__ Other: (Describe)____

Please include organization/program brochure(s) when possible.

*This is where we will mail the accreditation certificate unless otherwise indicated below

____

The complete accreditation application (including all program information) may be Emailed to **accreditation@thenadd.org** or mailed to:
NADD Accreditation
321 Wall Street
Kingston, NY 12401

Payment of the application fee $500:

□ Check enclosed (Please make checks payable to NADD)

□ Electronic invoice requested (application will be processed once application fee is received)

***Please include program information form (below) for each program for which you are seeking accreditation (use additional sheets as needed)**

Program Information

Program name: ____

Program address if different than principal organization address:

____

____

____

Contact Person: ____

Phone: _______________________ Email: _________________________________

Program description: ____

____

____

How many total people are served in the program for which you are seeking accreditation? _____

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

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+)	_____%

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
__ Other: ________________
__ Rehabilitation
__ Education

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

____

____

What is the total number of staff employed in the Program(s) for which you are seeking Accreditation? ___________________

a. Total number of Clinical staff ______

b. Total Number of Specialists _____

c. Total Number of Direct Support Professional Staff (DSP) ____
(Definitions for these positions can be found on pages 31-32 of the Program Manual)