

## **Application for Accreditation**

### **Information about Organization**

Name of Organization: \_\_\_\_\_

Principal mailing address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Name of CEO of Organization \_\_\_\_\_

\_\_\_\_\_

1. Does your Organization currently have Certification / Accreditation?

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 in your organization. \_\_\_\_\_

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

4. 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)

Acute Inpatient Hospital / Emergency Response /Crisis

Psychiatric

Rehabilitation

Medical

Traumatic Brain Injury  
TBI

Behavioral

Partial Hospital

Community or Mobile

Outpatient

Team

Residential / RTF

Family Based (Child)

Education / School

In Home Supports (adults)

Day Habilitation

Supports Coordination

Supported Employment

/Case Management

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

5. How many people with a Dual Diagnosis (IDD/MI) does the program currently serve?

\_\_\_ 1- 10

\_\_\_ 50-75

\_\_\_ 150 -200

\_\_\_ 10-25

\_\_\_ 75 - 100

\_\_\_ 200+

\_\_\_ 25- 50

\_\_\_ 100- 150

6. 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+

7. Does your program operate and provide services under state / local or other approval process?

\_\_\_ Yes \_\_\_ No

If Yes, please check or describe in other category

\_\_\_ Mental Health (MH)

\_\_\_ Intellectual Disability  
(ID)

\_\_\_ Medical

\_\_\_ Rehabilitation

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

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

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**Application should be mailed to:**

NADD Accreditation & Certification Programs  
132 Fair Street  
Kingston, NY 12401-4802

**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: \_\_\_\_\_