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: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

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: _____

_____

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.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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: _____