Iowa Department of Human Services

Application for Chapter 24 Accreditation

Provider Agency Name	
Address	Agency Phone Number
Contact Person	Website Address
Email Address	Telephone Number

This is: ☐ **Initial** application or ☐ **Renewal** application: Date of expiration: _____

NPI Numbers: _____

Type of organization:

- ☐ Case management
- ☐ Community supported living arrangements
- ☐ Crisis response
- ☐ Designated community mental health center
- ☐ Mental health service providers

Check the appropriate services for which you seek accreditation:

- ☐ Case management
- ☐ Supported community living services
- ☐ Intensive outpatient/day treatment
- ☐ Psychiatric rehabilitation services
- ☐ Outpatient psychotherapy/counseling services
- ☐ Partial hospitalization services
- ☐ Emergency services
- ☐ Evaluation services
- ☐ Crisis Stabilization Residential Services (CSRS)
- ☐ Crisis evaluation
- ☐ Twenty-four-hour crisis response
- ☐ Twenty-four-hour crisis line
- ☐ Warm line
- ☐ Mobile response
- ☐ Twenty-three-hour crisis holding/observation
- ☐ Crisis Stabilization Community-Based Services (CSCBS)

Name of Chief Executive Officer	Name of Chairperson of Governing Body
Signature of Chief Executive Officer	Signature of Chairperson of Governing Body

Identify administrative office locations for the accredited services to be provided:

Site name
Address
Phone
Services

Site name
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