



Universal Service Administrative Company

RURAL HEALTH CARE DIVISION

Community Mental Health Center Certification

NAME: _____

Recently you filed FCC Form 465 certifying eligibility as a Community Mental Health Center (CMHC). To assist us in verifying your eligibility for telecommunications support as a CMHC, please answer the following questions. Your application cannot be posted until we receive your response.

Instruction for completing the Community Mental Health Center Certification:

1. Name should be the name of the facility in Block 1, Line 3 of the FCC Form 465.
2. Proceed to check off the services **provided at the physical location** of the facility for which you are applying for eligibility to participate in the program.
3. Sign and Date the form

******PLEASE TAKE SPECIAL NOTICE OF THE FOLLOWING INSTRUCTION******

A behavioral health care organization may operate multiple facilities, some of which may not qualify for support. Each site or building is a separate applicant. The following form MUST be completed ONLY for the services provided at the physical location of the site for which you are requesting eligibility.

Please check all services that apply. If your health care organization operates more than one site, please complete a separate FCC Form 465 for each physical location eligible to participate in the program.

Sign and date this document and email, fax or mail it with attention to Jeff Rubin:

Email: jrubin@rhc.universalservice.org

Fax: 973-599-6514

Address:

Rural Health Care

Attn: Jeff Rubin

30 Lanidex Plaza West

PO Box 685

Parsippany, NJ 07054

HCP NAME: _____

HCP PHYSICAL ADDRESS: _____

SERVICES OFFERED AT THIS FACILITY:

- _____ Services principally to individuals residing in a defined geographic service area
- _____ Outpatient services
- _____ Specialized outpatient services for children _____ elderly _____
- _____ Specialized outpatient services for individuals with a serious mental illness
- _____ Services for patients who were discharged from inpatient mental health treatment
- _____ 24-hour-a-day emergency care services
- _____ Day treatment or other partial hospitalization services
- _____ Psychosocial and/or Vocational rehabilitation services
- _____ Screening for admission to State mental health facilities
- _____ Residential alcohol or substance abuse treatment services
- _____ Residential assisted living services for the mentally ill
- _____ **Residential Services (any type of residential living) **Send Letter w/explanation**
- _____ Services without regard to ability to pay, within the capacities of the center
- _____ Services from licensed onsite professionals during all _____ some _____ operating hours
- _____ Services from licensed offsite professionals during all _____ some _____ operating hours, provide by televideo _____ telephone _____ Internet _____
- _____ Services to offsite patients via televideo _____ telephone _____ Internet _____
- _____ Referrals to offsite licensed mental health professionals

Name: _____ Title: _____ Date: _____