

**GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
BEHAVIORAL HEALTH SERVICES**

REQUEST TO ADD COUNTIES TO EXISTING SERVICE SITE FORM

Legal Name:		
APS Audit Scores: List Date and Last Two APS Audit Scores:		
APS Audit Score: _____ Date of Audit: _____		
APS Audit Score: _____ Date of Audit: _____		
Service:		
Population:	Adults	C&A
Site Name:		
Street Address:		
City:		State:
County:	Zip Code:	DBHDD Region:
Site Telephone Number:		Site Fax Number:

Additional Counties Requested To Be Served From This Site:

(Counties requested must be within a 50 mile radius of this site)

Request Submitted By: _____

Title: _____

Signature: _____

Date: _____

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Please submit the following information with request:

- 1. Updated Organizational Chart for this site**
- 2. Copy of Professional Certificate/License of all credentialed staff listed on Organizational Chart**

Submit Completed Request To:

**Office of Provider Network Management
The Department of Behavioral Health and Developmental Disabilities
State of Georgia
2 Peachtree St., NW, Suite 23-247
Atlanta, GA 30303**

Submit Questions To: mhddad-serviceapps@dbhdd.ga.gov