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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-03313 (12/2024) | **STATE OF WISCONSIN**Page 1 of 2 |

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| **MENTAL HEALTH AND SUBSTANCE USE****CHANGES TO PROVIDER INFORMATION**  | **Internal Use Only** |
| Date Received:       |
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| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov**.**The clinic shall notify the department of any changes in administration, ownership or control, office location, clinic name, or program, and any change in the clinic's policies or practices that may affect clinic compliance by no later than the effective date of the change.Surveyor approval may be required prior to changes being accepted.  |
| 1. **GENERAL INFORMATION – ENTITY / ENTITY OWNER REQUESTING CERTIFICATION**
 |
| [ ]  **Main Clinic Move**  |
| [ ]  **Branch Move**  |
| **[ ]  Contact Change** (Name, phone, email, etc.) |
| **Current Certified Location** |
| Facility Name (Should match signage and Medicaid enrollment, if applicable)      | Certification Number     | Facility Phone Number      |
| Facility Street Address      | Location – Street Address/Room Number       | City      | ZIP Code      | County       |
| Current Contact – Name       | Current Contact – Phone Number      | Current Contact – Email Address      |
| **Clinic Change Information –** If applicable  |
| Facility Name (Should match signage and Medicaid enrollment, if applicable)      | Facility Phone Number       |
| Facility Street Address      | Location – Street Address/Room Number       | City      | ZIP Code      | County       |
| **Current Branch Location –** If applicable  |
| Branch Name      |
| Branch Street Address      | Location – Street Address/Room Number      | City      | ZIP Code      | County       |
| **Branch Change Information –** If applicable  |
| Branch Name      |
| Branch Street Address      | Location – Street Address/Room Number       | City      | ZIP Code      | County       |
| **Contact Change –** If applicable |
| New Contact – Name       |
| Email Address      | Contact Phone Number      |
| **Attestation** |
| I hereby attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge.I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32). |
| **Signature** – Entity Owner, Representative, or Authorized Representative  | Date Signed      |
| Name – Owner or Representative       | Title – Owner or Representative       |