To verify the eligibility of this Community Mental Health Center to participate in the Rural Health Care Support Mechanism, complete the following information and provide a copy of the health care provider’s (HCP) operating license and the operating license/certification number. This form and the HCP’s operating license (and the operating license/certification number) must be submitted with the FCC Form 460 or 465.

To the extent the Community Mental Health Center includes a long-term care facility, such as a residential substance abuse treatment center, that portion would not be eligible for support.

Complete the information below and check the services **provided at the physical location** of the HCP:

**HCP NUMBER (if known):**

**HCP NAME:**

**HCP PHYSICAL ADDRESS:**

**State License/Certification (if available):** For the above physical location, provide a copy of the state license/certification and provide the license/certification number: __________________________

**Services Provided at the Physical Location (check all that apply):**

- [ ] The facility offers outpatient mental health treatment.
- [ ] The facility offers 24-hour emergency care for mental health patients.
- [ ] The facility provides day hospital treatment for mental health patients.
- [ ] The facility provides other partial hospitalization services for mental health patients.
- [ ] The facility provides psychosocial rehabilitation services.
- [ ] The facility provides pre-admission screening for patients being considered for admission to state mental health facilities.
- [ ] The facility provides residential treatment.

**Signature:** __________________________ **Date:** __________________________

**Name:** __________________________ **Title:** __________________________

**Email:** __________________________ **Phone:** __________________________