LOUISIANA DEPARTMENT OF HEALTH
Health Standards Section

Behavioral Health Service Provider Key Personnel Change Form

Section 1: Provider Information

Legal Entity Name	
Facility (DBA) Name	
Provider License #	**State ID#: BH**
Address	
Mailing Address *(if different)*	
Email *(facility)*	
Telephone *(not voicemail)*	**Fax**
Administrator	**Email** *(Administrator)*

Section 2: Personnel Change Information

Identify the position that is changing:

- ☐ **Administrator** *(the person with overall responsibility for the day-to-day administrative operations)*
- ☐ **Medical Director** *(the physician providing oversight of the clinical operations)*
- ☐ **Clinical Director** *(provides oversight for provider policy/procedure, client treatment plans and staff regarding the medical needs of the clients according to the current standards of medical practice and other duties)*
- ☐ **Clinical Supervisor** *(provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling and other duties)*
- ☐ **Addictionologist** *(if your Medical Director is not an addictionologist or does not meet all the required qualifications)*

Current / Previous employee in this position	
Proposed employee for this position	**Hire Date**

Section 3: Qualifications of Proposed Employee

Submit the required documentation listed below for the proposed employee:

Administrator:
- ☐ Resume

Medical Director, Clinical Director, Clinical Supervisor:
- ☐ Resume
- ☐ Active Medical License

Addictionologist:
- ☐ Resume
- ☐ Medical License
- ☐ Addiction Medicine Certification

*****Any other supporting documentation showing proposed employee meets the required qualifications*****

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Section 4: Attestation of Compliance

I certify that the proposed employee listed herein meets all state/federal requirements set forth by the Louisiana Department of Health (LDH), HSS; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state/federal regulations on an ongoing basis, and that the LDH, HSS will be promptly notified of any changes to key personnel.

Authorized Representative's Printed Name & Title:	
Authorized Representative's Signature:	**Date:**

Email form <u>and</u> supporting documents to: HSS-BHSProviders@la.gov