

### Program Changes for Rehabilitative Behavioral Health Services

This form shall be completed and submitted to the Division of Behavioral Health for each office location via the following options:

Email: [behavioralhealth002@scdhhs.gov](mailto:behavioralhealth002@scdhhs.gov) or Fax: (803) 255-8204.

#### PROVIDER INFORMATION

Legal Name of Organization:			
Address:			Suite:
City:		State:	Zip Code:
Phone:		Fax:	
NP #:		Medicaid ID #:	
Primary Contact Name:		Primary Contact Title:	
Primary Contact Phone:		Primary Contact Fax:	
Primary Contact Email Address:			

#### PROGRAM CHANGES

<ul style="list-style-type: none"> <li>Provide pertinent details for each applicable change, including but not limited to: name(s) of new staff, effective date of each change, conditions of status changes, expiration dates, etc.</li> <li>Evidence for each applicable change must be submitted with this form</li> <li>Refer to the Reporting Program Changes section of the RBHS manual for further information</li> </ul>	
Change in Administrator (CEO/Director):	
Change in Clinical Director:	
Change in the number of RBHS staff resulting in less than two professional or paraprofessional staff available to provide services at any time :	
Adverse event(s) concerning staff licensure:	

Any change in accreditation status:	
Any change in facility license:	
Other:	
Other:	

Signature of Provider Representative:	Date:
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SCDHHS Use Only	
Date received:	Received by:
Actions taken:	