Mike Braun, Governor
State of Indiana

Indiana Family and Social Services Administration
Division of Mental Health and Addiction
402 W. WASHINGTON ST., ROOM W353
INDIANAPOLIS, IN 46204-2739

Recovery Residence Registration

INSTRUCTIONS:

1. **Complete application and sign application.**
2. **Email application and required documents to DMHAhousing@fssa.in.gov.**

Organization Information	
Select One ❑ New ❑ Renewal	
Name of Entity	
Doing Business As (DBA) Name of Organization, ***if Different from Above***	
Employer Identification Number ***(If Applicable)***	**Organization Type** (Check One) ☐ Governmental Entity ☐ Nonprofit ☐ For-Profit
Director	
Director Telephone Number	**Director Email Address**
Headquarters Address	
City, State and ZIP code	**County**
Mailing Address of Organization – If Different from Address Above	
City, State and ZIP code	**County**
Business Telephone Number	**Organization Fax Number**
Website (If Available)	

Three (3) letters of reference from the community; include contact information of the person making the reference – Attach copies with this application.

- **Reference Name #1**
- **Reference Name #2**
- **Reference Name #3**

Attestations (Confirm the following statements by signing below)	
You attest that the owner and/or director's qualifications and work experience align with operating a recovery residence *(Please list out qualifications and work experience)*	
You attest that all owners and staff are at least eighteen (18) years of age. Current proof of age is required to be attached to this application.	
You attest that the owners and staff will adhere to the ethical standards as set forth by NARR and the Division.	
You attest that your organization complies with nondiscriminatory state and federal requirements.	
You attest that claims in marketing materials and advertising will be honest and substantiated and that it does not employ any of the following: • False or misleading statements or unfounded claims or exaggerations; • Testimonials that do not reflect the real opinion of the individual involved; • Price claims that are misleading; • Therapeutic strategies for which licensure and/or counseling certifications are required but not applicable at the site; or • Misleading representation of outcomes.	
You attest that the electrical, mechanical, and structural components of the property are functional and free of fire and safety hazards.	
You attest that you operate the listed amount of recovery residences and agree to pay the initial fee(s) and renewal fee(s). *(The Division may not charge an owner a total amount for registration or renewal fees that exceed $2000 for each initial registration. The initial fee is $500 for each recovery residence, up to $2000 per owner. Each renewal is $350 per recovery residence, up to $2000 per owner).* **Total Recovery Residences: _____**	
Owner/Director Signature	Date (month, day, year)
Printed Name	

FOR DMHA USE ONLY		
Date Registration Fee Paid in Full (month, day, year)		
Notes:		
Registration Code	Effective Date:	Expiration Date:

If you have more than 3 recovery residences, please print additional Recovery Residence Information (pg. 4) sheets to submit with your application.

Recovery Residence Information	
Name of Facility	
Address of Facility	
City, State and ZIP code	**County**
Telephone Number	**Fax Number**
Zoning Information (attach documentation of official zoning decision)	
Number of Beds:	
National Alliance for Recovery Residences (NARR) Level:	
Populations Served (*Check all that apply.)* ❑ Men ❑ Women ❑ Pregnant Women ❑ Women and their children	

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