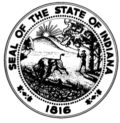

MOBILE CRISIS RESPONSE DESIGNATION APPLICATION

State Form 57289 (6-23)
FAMILY SOCIAL SERVICES ADMINISTRATION

Applicant Information

Organization Name: ______________________________ Date: ______________

Address: ____
Street Address

____
City *State* *ZIP Code*

Contact Person: Name: ______________________________

Telephone: ______________________ E-mail: ______________________

Total Number of Mobile Crisis Response Teams ______

Shift Times (should total 24 hours)	Number Mobile Crisis Response Teams available for Dispatch

What counties will be served by the mobile crisis teams?

____

____

____

Identify the specific suicide risk screen/assessment used: ______________________

Identify the specific safety risk screen/assessment used: ______________________

Identify the Level of Care assessment used: ______________________

Identify the Agency current contract, certification and/or accreditation for providing behavioral healthcare services in Indiana and the date it will expire:

____

Printed Name: ______________________________

Job Title: ______________________________

Organization: ______________________________

E-mail: ______________________________

Telephone Number: ______________________________

Signature: ______________________________ Date: ______________