**Attestation**

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| --- | --- |
| To: | DPSQA Licensure and Certification  |
| From:  |  |
| CC:  |  |
| Date: |  |
| Re: | OBHA to CSSP  |

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, am attesting that I am enrolled as an Outpatient Behavioral Health Agency (OBHA) and therefore meet the certification requirements of Intensive CSSP Agency. I am requesting provisional Intensive CSSP Agency certification until July 1, 2023.

Agency Name:

Agency OBHA DPSQA Identification number:

Please sign and upload with CSSP application. <https://arkdhs.force.com/elicensing/s/>

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Signature Date