# CIMOR Organization Change Form
# Instructions

Complete one form for EACH Organization address requiring updates. If an entire site is moving and ALL services will be offered at the new location, one form will be accepted for the change. This form WILL NOT be accepted to request certification changes. Those requests must be made directly to the DBH Certification Unit.

**Definitions: Organization** - Provider or Agency
**Primary Address** - Physical Location of the Site
**Executive Director** - Chief Executive Officer or President

**Section 1: ALL FIELDS IN THIS SECTION ARE REQUIRED FOR ALL REQUESTS**

**Reason for Request** - Include a detailed description of the changes requested in the form. Completion of this description does not replace completing the rest of the form.
**Effective Date** - Date on which the changes will go into effect.

**Section 2: Complete ONLY if changes need to be made to the Organization Name or Executive Director**

**Previous Organization Name** - The former name of the organization that is currently showing in CIMOR.
**New Organization Name** - The organization name as you want it to read in CIMOR.

**NOTE**: The Parent Organization Name in CIMOR **MUST** exactly match the name registered on the agency's Federal Tax ID.

**Previous Executive Director** - The name of the former CEO/President as it currently appears in CIMOR.
**New Executive Director** - The name of the new CEO/President as you want it to appear in CIMOR. Please include the Executive Director's Title.

**Section 3: All fields are required when adding new locations or requesting changes to the Physical/Primary Billing and/or Mailing Address**

**Administrative Site** - Check this box if the site you are requesting changes for is the Administrative location.
**Previous Address** - Complete this information to identify the location in CIMOR requiring changes.
**New Address** - Complete this information when a change to the existing address is required or to add new site.
**Primary Address** - Physical address for the location. This is required on all sites in CIMOR.
**Billing Address** - Optional address can be added if different from the Physical address.
**Mailing Address** - Optional address can be added if different from the Physical and/or Billing address.

**NOTE** - New location must include a Primary Daytime Phone number and the additional 4 digit zip code extension.

**Section 4: Complete the Add/Delete drop down boxes ONLY if changes are required or for a new location**

**Add** - Select 'Add' for new programs that will be offered at the location.
**Delete** - Select 'Delete' for programs that will be no longer offered at the location.

**'Completed By' and 'Regional Representative' Digital Signatures are required for ALL Requests**

**Completed By** - Digital Signature of the person completing the form.
**Phone Number** - The primary daytime contact number for the person who digitally signed the request.

**Regional Representative Digital Signature is required for all requests.**

**E-mail the completed form with digital signature to the appropriate regional representative:**

Organization Change forms for MH Children's Programs in Service Areas 10 & 12 should be assigned to Moriah Taylor in the Western Region, Service Area 11 should be assigned to Melodie York in the Southeast Region, and Service Areas 14 & 15 should be assigned to Al Eason in the Eastern Region.

**Eastern Region: SUD** – Heather Schaffer (Heather.Schaffer@dmh.mo.gov 314-877-0378)
**MH Adult** – Bobbi Summers (Bobbi.Summers@dmh.mo.gov 314-877-0391)
**MH Youth** – LaShunda Tibbs-Tate (LaShunda.Tibbs-Tate@dmh.mo.gov 314-877-6202)
**Southeast Region: SUD & MH Adult** – Bobbi Summers (Bobbi.Summers@dmh.mo.gov 314-877-0391)
**MH Youth** – Melodie York (Melodie.York@dmh.mo.gov 573-218-6792)
**Western Region: SUD** – Angie Lewis (Angie.Lewis@dmh.mo.gov 816-482-5779)
**MH Adult** – Janet Munsterman (Janet.Munsterman@dmh.mo.gov 417-448-3463)
**MH Youth** – Moriah Taylor (Moriah.Taylor@dmh.mo.gov 816-482-5725)

For questions about this form, please contact your regional office at the numbers listed above.

# DEPARTMENT OF MENTAL HEALTH
# CIMOR ORGANIZATION CHANGE FORM

## SECTION 1: Identification and Reason(s) for Request (REQUIRED FOR ALL REQUESTS)

Organization Name: 

Reason for Request:

Effective Date of Changes: 

## SECTION 2: Organization Name & Executive Director (Complete ONLY if changes are required)

Previous Organization Name: 

New Organization Name: 

Previous Executive Director:
(Name/Title)

New Executive Director:
(Name/Title)

## SECTION 3: Address/Phone/Contact Person (Previous Address is required for all changes)

**Primary Address** (Physical Location of Site) Action ☐ Administrative Site

**Previous**

Street Address

City State Zip Code (xxxxx-xxxx)

**New**

Street Address

City State Zip Code (xxxxx-xxxx)

County

Primary Daytime Phone (xxx) xxx-xxxx Site Fax Number (xxx) xxx-xxxx

Primary Contact Person/Title Contact Person's Email Address

**Billing Address** Action [ ] [ ] Same as Primary

**Previous**

Street Address

City | State | Zip Code (xxxxx-xxxx)

**New**

Street Address

City | State | Zip Code (xxxxx-xxxx)

County

**Mailing Address** Action [ ] [ ] Same as Primary

**Previous**

Street Address

City | State | Zip Code (xxxxx-xxxx)

**New**

Street Address

City | State | Zip Code (xxxxx-xxxx)

County

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**SECTION 4: Select ADD or DELETE on appropriate levels of services. List the affected contract in the box at right.**

**Alcohol and Drug Abuse (ADA) Programs**

| Program | Action | | |
|---|---|---|---|
| **Targeted Prevention** | | Contract# | |
| **Primary Prevention** | | Contract# | |
| **Statewide Resource Center** | | Contract# | |

**DBH Certified Non-Contracted Services**

| Service | Action |
|---|---|
| **SUD Detoxification - Medical** | |
| **SUD Detoxification - Modified Medical** | |
| **SUD Detoxification - Social Setting** | |
| **SUD Residential** | |
| **SUD Opioid** | |
| **SUD Institutional Corrections** | |
| **SUD Outpatient – Community-based Primary Treatment** | |
| **SUD Outpatient – Intensive Outpatient Rehabilitation** | |
| **SUD Outpatient – Supported Recovery** | |
| **Outpatient Mental Health Youth** | |
| **Outpatient Mental Health Adult** | |

Completed By:

Contact Email

Primary Daytime Phone (xxxx) xxx-xxxx

Regional Rep:

Regional Representative Comments:

Modified Date: 6/23/2021 (rr)