Oklahoma Department of Mental Health and Substance Abuse Services

COMMUNITY- BASED STRUCTURED CRISIS CENTERS (CBSCC)
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

A. _____
(Legal Name of Organization) (Director)

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address of Treatment Facility)

D. Phone Number: _____ Fax Number: _____ E-mail: _____

E. Target Population:
- ☐ Females
- ☐ Males
- ☐ Adolescents
- ☐ Adults

F. The following services will be provided:

☐ Facility Based-Crisis Stabilization Services ☐ Urgent Recovery Clinic Services

G. Enclosed are the following:

1. A non-refundable fee (check or money order) payable to the Oklahoma Department of Mental Health and Substance Abuse Services in the amount of $1,000.

2. Copies of required information:
   - ___ (a) Organizational Chart with all names and positions delineated, as well as dates of hire
   - ___ (b) List of Board Members (including addresses and phone numbers) and Articles of Incorporation
   - ____(c) ***Current and approved* fire inspection** from **local fire department or State Fire Marshal** - **inspections from private companies will NOT be accepted.** ***(if violations are cited on an inspection, corrections must be noted as approved; report must be dated within the current year)***
   - ____ (d) Pursuant to provisions in OAC 450:23-19-3 (e), signed verification by the Executive Director of use of approved curriculum in accordance with the memo dated July 27, 2016; **OR** a complete copy of proposed curriculum for training for review by Provider Certification
   - ____ (e) Copy of agency policy(ies) to verify compliance with OAC 450:23-19-3 (d), including, as applicable, a policy statement that physical interventions are not permitted by agency policy
   - ____ (f) Completed attestation form (included below) indicating number of hours clinical director will serve at facility. (See 450:1-9-6)

H. ☐ I hereby request the ODMHSAS accept the national accreditation by JCAHO/CARF as meeting certain specific ODMHSAS standards as identified by the ODMHSAS. Documentation is submitted of the most recent accreditation survey, including survey reports of all visits by the accrediting organization, any reports of subsequent actions initiated by the accrediting organization, plans of correction, and the dates for which the accreditation has been granted.

Statement of Understanding
(Application will not be processed unless each item below is reviewed and checked by provider.)

☐ I understand that, as a new provider, I cannot contract with Oklahoma Health Care Authority (OHCA) for Medicaid reimbursement while in the Permit for Temporary Operation process, **which is a minimum of six months**. Once my agency receives a full certification, I can contact the OHCA directly at 800-522-0114 to inquire about receiving a contract with OHCA.

☐ I hereby assure that the applicant organization operates without discrimination as to race, color, gender, age, degree of disability, handicapping condition, veteran status, religion, or ethnic origin.

☐ I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

☐ As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.

☐ As an authorized representative of the applicant organization, I understand that the policies and procedures are part of this application and will need to be submitted for review, after the application and supporting documents in H and I are reviewed and approved.

☐ I understand that if I fail to provide required and requested materials within sixty days of receipt of the application, my application will be denied.

☐ ***I acknowledge that my agency's certification review will be conducted under the ODMHSAS Standards and Criteria in effect at the time application is made.*** **(OAC 450:1-1-3)**

☐ I understand that consumer treatment records, reviewed during the subsequent review, may have any payer source: Medicaid, private pay, insurance, Community Sentencing, etc.

_____ _____
(Date) (Signature of Program Director)

_____
(**Printed** Name of Program Director)

_____ _____ _____
(Date) (Signature of Clinical Director) (Credentials)

_____
(**Printed** Name of Clinical Director)

An **FAQ** portion may be accessed on the ODMHSAS website at https://www.ok.gov/odmhsas/Additional_Information/Provider_Certification/Frequently_Asked_Questions_-_ODMHSAS_Certification.html. It covers questions ranging from the application process to the certification process. There are also topics addressed that relate to specific rules. These topics can be located at: https://www.ok.gov/odmhsas/Additional_Information/Provider_Certification/Communication_to_Providers_.html. Please utilize both of these links as a resource.

(revised 10/9/2018 – CL)

Attestation of Clinical Director's Hours

By signing below, I _____, attest that
(Printed Clinical Director's Name and Credentials)

I am the clinical director _____ hours each week at _____
(# hours) (Name of Company)

at the main facility located at _____
(full address of main facility – address, city, zip)

_____
Printed Clinical Director' Name and Credentials

_____
Signature of Clinical Director

_____
Date

_____
Printed Facility Director's Name

_____
Signature of Facility Director