Oklahoma Department of Mental Health and Substance Abuse Services

COMPREHENSIVE COMMUNITY ADDICTION RECOVERY CENTER (CCARC)
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. _____
(Administrative/Mailing Address)

C. Addresses for all locations providing, or planning to provide, services by your program as indicated in paragraphs F and G of the application, including the administrative location if providing services: (please attach a separate page, if necessary).

_____

_____

E. Phone Numbers: _____ (admin. and physical)

Fax Number: _____ E-Mail: _____

F. Required Core Services:

- ☐ Screening and referral services
- ☐ Emergency services
- ☐ Outpatient services based on ASAM PPC
- ☐ Intensive outpatient services based on ASAM PPC
- ☐ Case management services
- ☐ Rehabilitation services
- ☐ Medication clinic services
- ☐ Facilitation to medical withdrawal management services based on ASAM PPC
- ☐ Facilitation to residential substance abuse treatment based on ASAM PPC
- ☐ Services to homeless individuals
- ☐ Peer support services
- ☐ Wellness activities and support
- ☐ Ambulatory withdrawal management (adults only) based on ASAM PPC

G. Optional Services:

- ☐ Residential treatment for adults
- ☐ Intensive residential treatment for adults
- ☐ Residential treatment for persons with dependent children
- ☐ Adult residential treatment for consumers with co-occurring disorders
- ☐ Residential treatment for adolescents
- ☐ Adult halfway house
- ☐ Adolescent halfway house
- ☐ Halfway house for persons with dependent children
- ☐ Vocational employment
- ☐ Medically-supervised withdrawal management
- ☐ Non-medical withdrawal management
- ☐ Gambling Treatment Services

H. Number of active clients:

Co-Occurring _____ Alcohol and Drug _____

Mail application, documents requested in L, and check to:
ODMHSAS Provider Certification, 2000 N. Classen Blvd., 2-600, Oklahoma City, OK 73106
(405) 248-9029

I. Target Population:

☐ Females ☐ Adolescents
☐ Males ☐ Adults

J. For **Residential Treatment and/or Halfway House Services**, facility bed capacity, **regardless of payer source**:

Residential bed capacity: _____ Halfway House bed capacity: _____

K. Facility is currently certified for:

☐ Alcohol and Drug (OAC 450:18) ☐ CMHC (OAC 450:17)

L. 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) ***Current and approved fire inspection*** from **local fire department or State Fire Marshal** for each site/satellite location - **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)***
   - ☐ (b) Organizational Chart with all names and positions delineated, as well as dates of hire
   - ☐ (c) List of board members, including addresses and phone numbers, Certificate of Incorporation (or Limited Liability Company), and Articles of Incorporation
   - ☐ (d) **If application is made for residential treatment or halfway house**, current official documentation (e.g., zoning board, city manager) affirming that the facility is located in compliance with applicable zoning ordinances ***(refer to Title 43A of the Oklahoma Statutes § 3-417.1)***
   - ☐ (e) **If application is made for residential treatment or halfway house**, current official documentation (e.g., school superintendent, school principal, school board, land surveyor) affirming that the facility is not located within one thousand (1000) feet of any public AND private elementary AND secondary schools ***(refer to Title 43A of the Oklahoma Statutes § 3-417.1)***
   - ☐ (f) **For residential treatment or halfway house programs,** written treatment schedule.
   - ☐ (g) If providing on-premise meal service, most recent Oklahoma State Dept. of Health (OSDH) inspection. If on-premise meal service provided and no current inspection, refer to Notification of Procedures to Determine Compliance with Food Service Standards dated September 28, 2012.
   - ☐ (h) Pursuant to provisions in OAC 450:24-19-3 (d), 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.
   - ☐ (i)Copy of agency policy(ies) to verify compliance with OAC 450:24-19-3 (c), including, as applicable, a policy statement that physical interventions are not permitted by agency policy.
   - ☐ (j)Completed attestation form (included below) indicating number of hours clinical director will serve at primary facility. (See 450:1-9-6) NOTE THAT POLICIES MUST ADDRESS CLINICAL DIRECTOR'S HOURS AT ALL SATELLITE LOCATIONS.
   - ☐ (k) Include photographs of internal (entry/reception area) and external facility
3. ☐ Staff credentials (license) for licensed clinical director. (See 450:1-9-6) The application cannot be

processed if staff credentials related to this requirement are not provided with application materials. See Chapter 18 for licensing and credentialing information.

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.

☐ If applicant agency has a national accreditation by JCAHO/CARF/COA/AOA, request is made to accept the accreditation as compliant with certain specific ODMHSAS standards. ***Documentation MUST be included: current accreditation status, the programs included in the most recent accreditation survey, survey reports, reports of subsequent actions initiated by the accrediting organization, plans of correction if applicable, and the time period for which accreditation has been granted.***

☐ No accreditation - not applicable

☐ 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 L 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 or Licensed Staff) (Credentials)

_____
(**Printed** Name of Clinical Director Or Licensed Staff)

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.

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(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