Oklahoma Department of Mental Health and Substance Abuse Services

COMMUNITY MENTAL HEALTH CENTER
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. _____
(Administrative/Mailing Address)

C. Addresses for all sites/satellite locations providing services as indicated in paragraphs "E" and "F" of the application, and services provided at each: _____

_____

_____

_____

Service area proposed: _____

D. Administrative Phone and Fax Numbers: _____ _____

E-mail: _____

E. **CMHC Required Core Services**:
- ☐ Screening, assessment and referral services
- ☐ Emergency services
- ☐ Outpatient therapy services
- ☐ Case management services
- ☐ Psychiatric rehabilitation services
- ☐ Medication clinic services
- ☐ Services to homeless individuals
- ☐ Peer support services
- ☐ Wellness activities and support

F. **CMHC Optional Services:**
- ☐ Day treatment services to children and adolescents
- ☐ Vocational employment services
- ☐ Community living programs
- ☐ Inpatient services within the CMHC setting
- ☐ Gambling Treatment 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 the following 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, and Certificate of Incorporation

☐ (d) Pursuant to provisions in OAC 450:17-21-3 (d), signed verification by Executive Director of use of an 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 450:17-21-3 (c), including, as applicable, a policy statement that physical interventions are not permitted by agency policy

☐ (f) 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.

☐ (g) 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;

☐ (h) Include photographs of internal (entry/reception area) and external facility

☐ (i) If inpatient services are provided, copy of Oklahoma State Department of Health (OSDH) inspection. (See 450:17-5-95)

H. ☐ I hereby request the ODMHSAS accept the national accreditation by JCAHO/CARF/COA/AOA 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.

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

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

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

L. ☐ ***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)**

_____ _____

(Date) (Signature of Program Director)

_____

(**Printed** Name of Program Director)

_____ _____ _____

(Date) (Clinical Director or Licensed Staff) (Credentials)

_____

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

(revised 10/5/2018 - CL)