Oklahoma Department of Mental Health and Substance Abuse Services

EATING DISORDER TREATMENT PROGRAMS
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address of Treatment Facility)

Directions to facility: _____

D. Phone Number: _____ Fax Number: _____

E-mail: _____

E. Target Population:

☐ Females ☐ Adolescents
☐ Males ☐ Adults

F. 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** - **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) Staff credentials (license) for licensed clinical director. (See 50:1-9-6) The application cannot be processed if staff credentials related to this requirement are not provided with application materials.
   - ☐ (e) 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.
   - ☐ (f) Include photographs of internal (entry/reception area) and external facility

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

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

☐ 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.

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

☐ 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 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 F 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)**

_____ _____
(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.

(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