Oklahoma Department of Mental Health
and Substance Abuse Services

GAMBLING TREATMENT PROGRAM
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 physical address from nearest highway: ______________________________

____

D. Addresses for all locations at which you propose to provide services:

____Number of active clients_____
____ Number of active clients_____
____ Number of active clients_____

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

Fax Number:_______________ E-Mail: ______________________________

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 $300.00

2. Copies of required information:
   - ☐(a) ***Current and approved*** ***fire inspection (corrections must be noted as approved if violations were cited, and report must be dated within the current year)*** from **local fire department or State Fire Marshal** for each site/satellite location **(inspection will not be accepted from a private company);**
   - ☐ (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

3. Staff credentials (licenses) must be submitted for review prior to an initial site visit. An initial review and a certification status cannot be granted if the agency does not have appropriately licensed staff. (See Chapter 65 for licensing and credentialing information.)

4. Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)

5. I hereby request the ODMHSAS accept the national accreditation by JCAHO/CARF/COA/AOA 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.***

G. ☐ 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.

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

I. ☐ ***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)

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

(revised 2/28/2017 - CL)