Oklahoma Department of Mental Health and Substance Abuse Services

OUTPATIENT MENTAL HEALTH TREATMENT
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. _____
(Administrative/Mailing Address)

C. Addresses for all sites/locations* at which you propose to provide services as indicated in paragraph "E" of the application, including the administrative location if providing services: (please attach a separate page if necessary)

_____

_____

A site is defined as an office, clinic, or other business setting where Outpatient Mental Health Services are routinely performed.

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

Fax Number:_____ E-Mail: _____

E. In addition to the required core services (screening, assessment and referral services, emergency services, and outpatient therapy services), the following optional services will be provided:

- ☐ Case Management Services
- ☐ Medication Services
- ☐ Pharmacy Services
- ☐ Peer Recovery Support Services**
- ☐ Wellness Activities and Supports
- ☐ Behavioral Health Rehabilitation Services
- ☐ Day treatment services for children and adolescents

****Peer Recovery Support Services are ONLY reimbursable through a contract with ODMHSAS** (https://www.ok.gov/odmhsas/Additional_Information/Provider_Certification/Frequently_Asked_Questions_-_ODMHSAS_Certification.html)

F. Number of active clients: _____ Please estimate number to be served _____

G. Population to be served (*please check all that apply)*:

- ☐ Females
- ☐ Males
- ☐ Children
- ☐ Adolescents
- ☐ Adults
- ☐ Older Adults

H. Facility is currently **certified** by ODMHSAS for:

- ☐ Community Residential Mental Health (OAC 450:16)
- ☐ CMHC (OAC 450:17)
- ☐ Alcohol and Drug (OAC 450:18)
- ☐ CBSCC (OAC 450:23)
- ☐ Addiction Recovery (OAC 450:24)
- ☐ PACT (OAC 450:55)
- ☐ Eating Disorders (OAC 450:60)
- ☐ Gambling Treatment (OAC 450:65)
- ☐ Opioid Substitution Treatment (OAC 450:70)
- ☐ Outpatient Mental Health (OAC 450:27)

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

I. Enclosed are the following:

1. ☐ A non-refundable fee (check or money order – CASH IS NOT ACCEPTED) 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 (names of staff must be included, if hired);

☐ (c) Certificate of Incorporation or Limited Liability Company (current Okla. Secretary of State Documentation/Secretary of State seal) and Articles of Incorporation;

☐ (d) List of board members, including addresses and phone numbers (addresses and phone numbers cannot be the company's address and phone number);

☐ (e) Staff credentials (**copy of licenses**) for clinical director. (See 450:1-9-6) Outpatient mental health clinical directors must be fully licensed in a mental health field (LPC, LMFT, LBP, LCSW, LADC-MH, or a licensed psychologist). The application cannot be processed if documentation of staff credentials related to this requirement are not provided with application materials.

☐ (f) 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.

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

☐ (h) Documentation to verify staff training regarding the location and use of all fire extinguishers and first aid supplies and firefighting equipment/fire detection systems (See OAC 450:27-3-41)

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.

☐ 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 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, 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