Oklahoma Department of Mental Health and Substance Abuse Services

OPIOID SUBSTITUTION TREATMENT
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. ____
(Administrative/Mailing Address)

C. Physical address for the location at which you propose to provide services:
____

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

Fax Number:_______________ E-Mail: ______________________________

E. 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 - 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) Current official documentation (e.g., zoning board, city manager) affirming that the treatment facility is located in compliance with applicable zoning ordinances
   - ☐ (e) Include photographs of internal (entry/reception area) and external facility
   - ☐ (f) Copies of all planned promotional materials, advertisements, and marketing strategies to publicize the proposed program. [OAC 450:70-4-6 (a) (1)]
   - ☐ (g) Policies and procedures that will be used to identify if a patient is enrolled in another clinic. [OAC 450:70-4-6 (a) (2)]
   - ☐ (h) The source and adequacy of financial assets necessary to operate the program. [OAC 450:70-4-6 (a) (3)]
   - ☐ (i) Document the need for new services in the area as demonstrated by providing ODMHSAS with waiting lists, numbers of opioid related emergency room visits, opioid related arrest data, and federal drug use forecasting data. [OAC 450:70-4-6 (a) (7)]
   - ☐ (j) Demonstrate general community acceptance by providing ODMHSAS with copies of letters of support from local authorities and local residents living near the site. [OAC 450:70-4-6 (a) (8)]
   - ☐ (k) Completed attestation form (included below) indicating number of hours Medical Director will serve at listed facility. (OAC 450:7-4-4.2)

3. Staff credentials 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.

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

(See Chapter 70 for licensing and credentialing information.)

Statement of Understanding

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

☐ The applicant has read, understood and agrees to follow all federal and state regulations concerning operation of an OTP. [OAC 450:70-4-6 (a) (6)]

☐ 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 E 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 Sponsor)

____
(**Printed** Name of Program Sponsor)

______________________ ____________________________________ ____________
(Date) (Signature of Medical Director) (Credentials)

____
(**Printed** Name of Medical 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