

Oklahoma Department of Mental Health
and Substance Abuse Services

PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT
INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address of Treatment Facility)

D. Phone Number: _____ Fax Number: _____

E-mail Address: _____

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) and Certificate of Incorporation

(d) Completed attestation form (included below) indicating number of hours clinical director will serve at primary facility. (See 450:1-9-6)

F. 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.

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