



**INITIAL APPLICATION  
ALCOHOL AND DRUG TREATMENT**

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- (c) List of board members, including addresses and phone numbers, Certificate of Incorporation (or Limited Liability Company), and Articles of Incorporation
- (d) Program Description for each component or service
- (e) If providing on-premise meal service, most recent Oklahoma State Dept. of Health (OSDH) inspection. If on-premise meal service provided and no current inspection, refer to attached memo (Notification of Procedures to Determine Compliance with Food Service Standards dated September 28, 2012)
- (f) Current official documentation (e.g., zoning board, city manager) affirming that each treatment facility is located in compliance with applicable zoning ordinances (**refer to Title 43A of the Oklahoma Statutes § 3-417.1**)
- (g) If application is made for residential treatment or halfway house, official documentation (e.g., school superintendent, school principal, school board, land surveyor) affirming that each treatment facility is not located within one thousand (1000) feet of any public AND private elementary AND secondary schools (**refer to Title 43A of the Oklahoma Statutes § 3-417.1**)
- (h) Staff credentials (licenses) for all licensed staff and clinical director. (See 450:1-9-6) The application cannot be processed if staff credentials related to this requirement are not provided with application materials. Staff shall have documented qualifications or training specific to the clinical services they provide. (See 450:18-1-9)
- (i) Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)
- (j) Include photographs of internal (entry/reception area) and external facility

3.  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.**

J.  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.

K.  I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

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

M.  **I acknowledge that my agency's certification review will be conducted under the ODMHSAS Standards and Criteria in effect at the time of the review.**

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Program Director)

\_\_\_\_\_  
(Printed Name of Program Director)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Clinical Director)

\_\_\_\_\_  
(Credentials)

\_\_\_\_\_  
(Printed Name of Clinical Director)