

**Oklahoma Department of Mental Health
and Substance Abuse Services**

**RENEWAL APPLICATION FOR CERTIFICATION OF
ALCOHOL AND DRUG TREATMENT**

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

B. _____
(Administrative/Mailing Address)

C. _____ Number of active A/D clients _____
(Physical Address)

New address(es)? Yes No

Directions to physical address from nearest highway: _____

D. Addresses for all locations providing, or planning to provide, services by your program as indicated in paragraph "G" of the application, **including correctional facilities**: (please attach a separate page, if necessary)

_____ Number of active A/D clients _____

_____ Number of active A/D clients _____

_____ Number of active A/D clients _____

New satellite address(es)? Yes No

(If yes, indicate which is the new address: _____)

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

Fax Number: _____ E-Mail: _____

F. Please check the services provided or to be provided:

- | | |
|--|--|
| <input type="checkbox"/> Medically Supervised Detoxification | <input type="checkbox"/> Residential Treatment for Co-Occurring Disorders |
| <input type="checkbox"/> Non-Medical Detoxification | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Adult Residential Treatment | <input type="checkbox"/> Adult Halfway House |
| <input type="checkbox"/> Residential Treatment for Persons with Dependent Children | <input type="checkbox"/> Adolescent Halfway House |
| <input type="checkbox"/> Adolescent Residential Treatment | <input type="checkbox"/> Halfway House for Persons with Dependent Children |
| <input type="checkbox"/> Adult Intensive Residential Treatment | <input type="checkbox"/> Gambling Disorder Treatment |
| <input type="checkbox"/> Peer Recovery Support Services | |

G. Target Population:

- | | |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Females | <input type="checkbox"/> Adolescents |
| <input type="checkbox"/> Males | <input type="checkbox"/> Adults |

H. Facility currently contracts with OHCA to provide Medicaid reimbursable services _____ (check if yes) or facility plans to contract with OHCA _____ (check if yes)

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- I. I have enclosed the following:
1. A 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 from the state or local Fire Marshal or local fire department for each site/satellite location (**inspection will not be accepted if it includes violations without corrections approved, if expired, or if not current within one year from date of inspection**)
 - (b) Organizational Chart with names and positions delineated
 - (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 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) **For residential treatment or halfway house programs**, 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. See Chapter 18 for licensing and credentialing information.
 - (i) Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)
 - (j) List of current and discharged clients specific to Alcohol and Drug Treatment. The charts should be complete open and active records and complete discharge records. Only charts that have been opened and/or discharged since the last review by Provider Certification should be listed. Please identify the clients by an identifying number and date opened or discharged – names, birthdates, and social security numbers should **not** be used.
 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. As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 18, need to be electronically submitted to Brenda Pitts at bpitts@odmhsas.org. **Hard copies or faxed copies of these items will not be accepted.**
- K. 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.
- L. I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

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

Failure to submit all documentation required for this application can result in expiration of certification.

(Date)

(Signature of Program Director)

(Printed Name of Program Director)

(Date)

(Clinical Director)

(Credentials)

(Printed Name of Clinical Director)

(revised 9/15/2015 – CL)