

Oklahoma Department of Mental Health
and Substance Abuse Services

**INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATION-
COMPREHENSIVE COMMUNITY ADDICTION RECOVERY CENTER (CCARC)**

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address)

Directions to physical address from nearest highway: _____

D. Addresses for all locations at which you propose to provide services as indicated in paragraphs "F" and "G" of the application:

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

Fax Number: _____ E-Mail: _____

F. Required Core Services:

- Screening intake and referral services
- Emergency services
- Outpatient services based on ASAM PPC
- Intensive outpatient services based on ASAM PPC
- Case management services
- Rehabilitation services
- Medication clinic services
- Facilitation to medical detoxification services based on ASAM PPC
- Facilitation to residential substance abuse treatment based on ASAM PPC
- Services to homeless individuals
- Peer support services
- Wellness activities and support
- Ambulatory detoxification (adults only) based on ASAM PPC

G. Optional Services:

- Residential treatment for adults
- Residential treatment for persons with dependent children
- Adult residential treatment for consumers with co-occurring disorders
- Residential treatment for adolescents
- Adult halfway house
- Adolescent halfway house
- Halfway house for persons with dependent children
- Vocational employment
- Medically-supervised detoxification
- Non-medical detoxification
- Gambling disorder treatment

H. Number of active clients:

Co-Occurring _____
Alcohol and Drug _____

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I. Target Population:

- Females Adolescents
 Males Adults

J. Facility is currently certified for:

- Alcohol and Drug (OAC 450:18) CMHC (OAC 450:17)

K. I have enclosed 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 \$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
 - (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) 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**)
 - (f) If application is made for residential treatment, halfway house, medically supervised detoxification, or non-medical detoxification services, 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**)
 - (g) Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)
 - (h) Include photographs of internal (entry/reception area) and external facility
 - (i) Include photographs of internal (entry/reception area) and external facility
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. (See Chapter 24 for licensing and credentialing information.)
4. 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.**

L. 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.

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

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

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- O. *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 or Licensed Staff)

(Credentials)

(**Printed** Name of Clinical Director Or Licensed Staff)