



H. 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 the following 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, and Certificate of Incorporation
  - (d) Program Description, including number of beds if allocated to inpatient
  - (e) Pursuant to provisions in OAC 450:17-21-3 (d), signed verification by Executive Director of use of an approved curriculum in accordance with memo from Durand Crosby, ODMHSAS Chief Operating Officer, dated April 3, 2009; **OR** a complete copy of proposed curriculum for training for review by Provider Certification
  - (f) Copy of agency policy(ies) to verify compliance with OAC 450:17-21-3 (c), including, as applicable, a policy statement that physical interventions are not permitted by agency policy

I.  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.

J.  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.

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 or Licensed Staff)

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

\_\_\_\_\_  
(Printed Name of Clinical Director Or Licensed Staff)