

Oklahoma Department of Mental Health
and Substance Abuse Services

RENEWAL APPLICATION FOR CERTIFICATION OF GAMBLING TREATMENT

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address)

New address(es)? Yes No

Directions to physical address from nearest highway: _____

D. Addresses for all locations providing, or planning to provide: (please attach a separate page, if necessary) _____ Number of active 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. 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
 - (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) Staff credentials (licenses) must be submitted for review prior to an initial site visit. A certification status cannot be granted if the agency does not have appropriately licensed staff. (See Chapter 65 for licensing and credentialing information.)
 - (f) Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)
 - (g) List of current and discharged clients specific to Gambling 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.

G. As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 65, need to be electronically submitted to Brenda Pitts at bpitts@odmhsas.org. **Hard copies or faxed copies of these items will not be accepted.**

H. 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.

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- I. I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.
- J. As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.
- K. ***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)