

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

**RENEWAL APPLICATION FOR CERTIFICATION  
OF  
COMMUNITY RESIDENTIAL MENTAL HEALTH FACILITIES**

A. \_\_\_\_\_  
(Legal Name of Organization) (Director)

B. \_\_\_\_\_  
(Administrative/Mailing Address)

C. \_\_\_\_\_  
(Physical Address)

Directions to facility from nearest highway: \_\_\_\_\_

D. Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

E. I hereby request a site review by representatives of the Department of Mental Health and Substance Abuse Services (DMHSAS) to determine compliance with DMHSAS Standards and eligibility to provide the following service(s):  Residential Care Facility  **Enhanced** Residential Care Facility

G. Bed Capacity:  
\_\_\_\_\_ # of Beds

H. Population:  
 Females  Males

- I. I have enclosed copies of the following information
- (a) A fee (check or money order) payable to the Oklahoma Department of Mental Health and Substance Abuse Services in the amount of \$100.00
  - (b) Current and approved fire inspection from the state or local Fire Marshal or local fire department
  - (c) Program Description
  - (d) Organizational Chart
  - (e) List of Board Members, including addresses and phone numbers
  - (f) Certificate of Incorporation or Limited Liability Company
  - (g) State Health Department Licensure
  - (h) State Health Department inspection (last complete inspection to include your facility's corrections and Health Dept. letter of acceptance)
  - (i) Documentation of administrator's training [See OAC 450:16-21-4 (a): **24 hours of training credit annually provided by an Oklahoma institution of higher learning or**

**ODMHSAS, 8 hours of hours of behavior management training by OSDH, CPR, and first aid]** **mental health related subjects, 1 hour of co-occurring, 3 training (pre-approved), 16 hours of required**

- (j) Administrator license from Okla. State Board of Examiners for Long-Term Care Administrators

J.  As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 16, need to be electronically submitted to Brenda Pitts at [bpitts@odmhsas.org](mailto: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.

**RENEWAL APPLICATION  
COMMUNITY RESIDENTIAL MENTAL HEALTH  
Page 2 of 2**

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 or Administrator)

\_\_\_\_\_  
**(Printed Name of Program Director or Administrator)**

(revised 9/15/2015 – CL)