



PERMIT FOR TEMPORARY OPERATION – INITIAL APPLICATION

OUTPATIENT MENTAL HEALTH TREATMENT ORGANIZATION FOR MENTAL ILLNESS SERVICES

Legal Name of Organization:

Name of Facility Director:

Organization Administrative Mailing Address

Phone Number:

Fax Number:

E-Mail for Administrative Contact:

Primary Physical Address and Phone Number (if different from mailing address):

Medicaid# _____ NPI# _____

Directions to physical address from nearest highway:

Addresses and phone numbers for all locations at which you propose to provide services that are indicated below: (add additional pages as needed)

Medicaid# _____ NPI# _____

Medicaid# _____ NPI# _____

In addition to the Required Core Services (screening intake and referral services, emergency services, and outpatient therapy services), the following optional services will be provided:

- Case Management Services, Medication Services, Pharmacy Services, Peer Recovery Support Services, Wellness Activities and Supports, Behavioral Health Rehabilitation Services, Day treatment services for children and adolescents

Number of active clients: _____ Please estimate number to be served _____

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

Population to be served (please check all that apply):

- Females, Males, Children, Adolescents, Adults, Older Adults

Facility is currently ODMHSAS certified for:

- Community Residential Mental Health (OAC 450:16), CMHC (OAC 450:17), Alcohol and Drug (OAC 450:18), CBSCC (OAC 450:23), Addiction Recovery (OAC 450:24), PACT (OAC 450:55), Eating Disorders (OAC 450:60), Gambling Treatment (OAC 450:65), Opioid Substitution Treatment (OAC 450:70), Outpatient Mental Health (OAC 450:27)

I have enclosed the following:

- 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

INITIAL APPLICATION - OUTPATIENT MENTAL HEALTH TREATMENT ORGANIZATION

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 (**for emergency services, referral agreements for provision of emergency services must be included**)
 - (e) Staff credentials (licenses) for all licensed staff and clinical director. (See 450:1-9-6) Outpatient mental health clinical directors must be fully licensed in a mental health field (LPC, LMFT, LBP, LCSW or a licensed psychologist). The application cannot be processed if documentation of staff credentials related to this requirement are not provided with application materials. See Chapter 27 for licensing and credentialing information.
 - (f) Number of hours clinical director will serve at each listed facility. (See 450:1-9-6)
 - (g) Include photographs of internal (entry/reception area) and external facility
- Documentation to verify staff training regarding the location and use of all fire extinguishers and first aid supplies and firefighting equipment/fire detection systems (See OAC 450:27-3-41).
 - Documentation to verify staff training regarding Universal Precautions (See OAC 450:27-3-62).
 - I hereby request the ODMHSAS accept the national accreditation by JCAHO/CARF/COA/AOA, if applicable, as compliant with certain specific ODMHSAS standards. Please provide the following: *current accreditation status, the programs included in the most recent accreditation, 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.*
 - 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.
 - I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.
 - I acknowledge that my agency's certification reviews will be conducted in accordance with the ODMHSAS Standards and Criteria in effect at the time of the review as codified in OAC 450.*

I am an authorized representative of the applicant organization and verify this application and all enclosed documents are true and correct.

Full Name: _____

Title: _____

Director Signature: _____ Date: _____

Printed Name: _____

Clinical Director Signature: _____ Credentials: _____

Printed Name: _____ Date: _____