

Oklahoma Department of Mental Health  
and Substance Abuse Services

**RENEWAL APPLICATION FOR CERTIFICATION OF  
OUTPATIENT MENTAL HEALTH TREATMENT**

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

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

C. \_\_\_\_\_ Number of active clients \_\_\_\_\_  
(Physical Address)

New address?  Yes  No

Directions to physical address from nearest highway: \_\_\_\_\_

D. Addresses for all locations providing, or planning to provide, services by your program as indicated in paragraph "G" of the application:

\_\_\_\_\_ Number of active clients \_\_\_\_\_

\_\_\_\_\_ 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. 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Case Management Services       | <input type="checkbox"/> Wellness Activities and Supports                    |
| <input type="checkbox"/> Medication Services            | <input type="checkbox"/> Behavioral Health Rehabilitation Services           |
| <input type="checkbox"/> Pharmacy Services              | <input type="checkbox"/> Day treatment services for children and adolescents |
| <input type="checkbox"/> Peer Recovery Support Services |  |

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

- |                                  |                                      |                                       |
|----------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Females | <input type="checkbox"/> Children    | <input type="checkbox"/> Adults       |
| <input type="checkbox"/> Males   | <input type="checkbox"/> Adolescents | <input type="checkbox"/> Older Adults |

H. Facility currently contracts with OHCA to provide Medicaid reimbursable services \_\_\_\_\_ (check if yes) or facility plans to contract with OHCA \_\_\_\_\_ (check if yes)

I. Facility is currently ODMHSAS certified for:

- |   |  |
|---|--|
| <input type="checkbox"/> Outpatient Mental Health (OAC 450:27)            | <input type="checkbox"/> Eating Disorders (OAC 450:60)   |
| <input type="checkbox"/> Community Residential Mental Health (OAC 450:16) | <input type="checkbox"/> Gambling Treatment (OAC 450:65) |
| <input type="checkbox"/> Opioid Substitution Treatment (OAC 450:70)       | <input type="checkbox"/> CMHC (OAC 450:17)               |
| <input type="checkbox"/> Alcohol and Drug (OAC 450:18)                    |  |
| <input type="checkbox"/> CBSCC (OAC 450:23)                               |  |
| <input type="checkbox"/> Addiction Recovery (OAC 450:24)                  |  |
| <input type="checkbox"/> PACT (OAC 450:55)                                |  |

J. 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

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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 (**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
- (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) List of current and discharged clients specific to Outpatient Mental Health. 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.

K.  As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 27, 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.**

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.

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.***

**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)