

Oklahoma Department of Mental Health
and Substance Abuse Services

RENEWAL APPLICATION FOR CERTIFICATION
OF
PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address)

Directions to facility _____

D. **Addresses for all sites/satellite locations providing services** _____

E. Phone Number: _____ Fax Number: _____

E-mail Address: _____

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) and Certificate of Incorporation
- (d) Program Description

G. 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.

H. As they are part of the application, the pre-Site Survey, supporting policies, procedures and other documents specific to Chapter 55, need to be electronically submitted to Brenda Pitts at bpitts@odmhsas.org. **Hard copies or faxed copies of these items will not be accepted.**

I. 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.

J. I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

- K. As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.

- L. ***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)