

Oklahoma Department of Mental Health
and Substance Abuse Services

**INITIAL APPLICATION FOR PERMIT FOR TEMPORARY OPERATIONS-
COMMUNITY RESIDENTIAL MENTAL HEALTH FACILITY**

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

B. _____
(Administrative/Mailing Address)

C. _____
(Physical Address)

Directions to physical address from nearest highway: _____

D. Phone Numbers: _____
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 non-refundable 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 mental health related subjects, 1 hour of co-occurring, 3 hours of behavior management training (pre-approved), 16 hours of required training by OSDH, CPR, and first aid**]
 (j) Administrator license from Okla. State Board of Examiners for Long-Term Care Administrators

J. 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.

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

M. ***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.***

(Date)

(Signature of Authorized Program Official)