

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES**  
**OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION**

(Read Instructions Carefully Before Completion)

**PART III – DESCRIPTION OF SERVICES**

Applicant's Legal Name	
Site/Additional Location Address <input type="checkbox"/> Not Yet Selected ( <b>New Providers Only</b> )	Service Type
<b>Note: Part III is completed by applicants who are new to OASAS and wish to operate one or more new services, or by existing OASAS providers who are seeking approval to provide new services or to establish a service at an additional location. Section H is omitted for services at additional locations.</b>	
<b>A.</b>	Indicate the type of site action applicant is requesting.
<b>Action Proposed</b>	<ul style="list-style-type: none"> <li>a.   <input type="checkbox"/> Provide a new service at this site</li> <li>b.   <input type="checkbox"/> Establish a service at an additional location at a <b>stand-alone location</b> (Outpatient Services Only)</li> <li>c.   <input type="checkbox"/> Establish a service at an additional location at <b>host agency</b> (Outpatient Services Only)</li> </ul> <p><i>If "at host agency", provide as <b>ATTACHMENT #13</b> a description of the arrangements and reasons for establishing the additional location at the host agency.</i></p>
<b>B.</b>	Provide a description of the area where the applicant plans to provide certified treatment services and describe how the service will function within the network of chemical dependence providers in this area.
<b>Description of Area to be Served</b>	
<b>C.</b>	Provide an assessment of the need for the services described in the application. In addition to the assessment, use existing OASAS need methodology where available.
<b>Assessment of Need</b>	Include as <b>ATTACHMENT #14</b> information relative to need as specified in the instructions.
<b>D.</b>	1. Describe the applicant's approach/philosophy regarding the treatment of chemical dependence; include use of self-help services, medication, individual/group counseling and other treatment techniques.
<b>Description of Services</b>	2. List and define the specific service components to be offered to patients, including any proposed time-structured treatment regimen or module. Include as <b>ATTACHMENT # 15</b> the description of service components requested per instructions.
	3. For each planned service, provide a detailed list including, but not limited to: expected outcomes for patients, planned numbers and frequency of service delivery, planned length of stay and other proposed measures of success. Include as <b>ATTACHMENT # 16</b> the description of goals and objectives, per instructions.

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Applicant's Legal Name															
Site/Additional Location Address <input type="checkbox"/> Not Yet Selected (New Providers Only)										Service Type					
<b>E.</b>	Indicate below any special populations that these services are specifically designed to treat (see instructions for definitions). <input type="checkbox"/> No Special Population(s) <input type="checkbox"/> Youth <input type="checkbox"/> Homeless <input type="checkbox"/> COSA/COA <input type="checkbox"/> Women <input type="checkbox"/> Elderly <input type="checkbox"/> Parole and/or Probation <input type="checkbox"/> LGBT <input type="checkbox"/> Pregnant Women <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Alternative to Incarceration <input type="checkbox"/> Intravenous Drug Users <input type="checkbox"/> Women w/Children <input type="checkbox"/> MICA <input type="checkbox"/> CASAT <input type="checkbox"/> Other (Specify) _____														
	<b>Special Populations</b>	Describe specific programmatic efforts to be undertaken to ensure that services are provided to special populations, if any are designated above.													
<b>F.</b>	<input type="checkbox"/> 24 hours per day, 7 days per week														
	<b>Proposed Operating Schedule (Specify a.m. or p.m.)</b>	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
		From	To	From	To	From	To	From	To	From	To	From	To	From	To
		Total Hours													
	Medication Hours*														
<b>*Opioid Treatment Services Only</b>															
<b>G. Projected Workload</b>	Indicate the projected annual volume of services that will be provided at the main location and the additional location, if applicable. <input type="checkbox"/> Not Applicable    _____ Annual Visits (Main Location)    _____ Annual Visits (Additional Location)														
<b>H.</b>	It is the applicant's responsibility to review all applicable operating regulations to ensure the policies and procedures submitted are complete and meet regulatory standards. <a href="#">Guidance for writing policies and procedures</a> can be found on the <a href="#">OASAS website</a> . The applicant must develop and submit as <b>Attachment #17</b> detailed chemical dependence operational policies and procedures in accord with proposed services to be provided, <b>including but not limited to</b> :  (Omit for services at additional locations)														
	<b>Operational Policies and Procedures</b>	• policies and procedures governing the criteria for the admission, continued stay and discharge of patients, including the ongoing evaluation process for identifying patients in need of a higher or lower level of care;													
		• policies and procedures for the preparation of individualized treatment plans, as appropriate, and for the preparation and maintenance of clinical records;													
		• policies and procedures for medical services and administration of medications;													
		• policies and procedures for conducting medical & laboratory tests, including staff involved & timeframes for testing;													
		• policies and procedures for identifying other medical and psychiatric conditions that require referral for acute medical and mental hygiene services;													
		• policies and procedures for the supervision of clinical care staff;													
		• policies and procedures for addressing quality improvement and utilization review;													
		• for applications involving <b>medically managed detoxification, medically supervised withdrawal and medically monitored withdrawal services</b> , policies, procedures and protocol governing withdrawal with medication, covering those issues specified in the instructions;													
		• policies and procedures governing a patient's rights to confidentiality;													
		• policies and procedures concerning HIV and AIDS;													
		• a patient's handbook of rights and responsibilities regarding participation in the services offered;													
		• procedures to provide patients with continuity of care consistent with treatment and discharge plans;													
		• policies and procedures governing billing and collection of patient fees;													
		• policies, procedures and methods governing patient rights;													
• policies, procedures and methods governing the provision of a tobacco-free environment;															
• policies, procedures and methods governing incident reporting; and															
• any other policies and procedures required by OASAS regulations.															
<b>NOTE: For new opioid services, complete remaining Sections I-O of Part III; for other new services, proceed to Part IV.</b>															

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Applicant's Legal Name					
Site/Additional Location Address <input type="checkbox"/> Not Yet Selected <b>(New Providers Only)</b>			<b>Service</b> <b>Opioid Treatment</b>		
<b>I.</b> <b>Key Opioid Program Staff</b>	Chief Executive Officer		Medical Director		
	Site Medical Director		Other (Specify)		
<b>J.</b> <b>Program Approval Status</b>	<b>Application     Submitted     Approved     Other</b>				
	Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (CSAT)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Drug Enforcement Administration		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NYS Department of Health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Include as <b>ATTACHMENT # 19</b> a copy of each application the applicant has submitted or other evidence that the approval process is in progress or that approval has been granted.</i>					
<b>K.</b> <b>Alternative Emergency Medication Procedures</b>	1. Describe arrangements for the medication of patients during emergency or holiday situations when the clinic is unable to open.				
	2. Indicate if the above arrangements are consistent with CSAT Guidelines. <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>L.</b> <b>Methadone Security</b>	1. Storage Arrangements				
	<input type="checkbox"/> On-Site (Complete #2 below)		<input type="checkbox"/> Off-Site Location (Complete #3 below)		
	2. Describe the alarm system and other security measures for on-site methadone storage.				
3. Describe security measures for the transport of methadone to and from the central pharmacy location.					

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Site/Additional Location Address <input type="checkbox"/> Not Yet Selected (New Providers Only)				Service <b>Opioid Treatment</b>	
<b>M.</b>          <b>Staffing</b>	<b>Staff Position</b>	<b>Name</b>	<b>License No.</b>	<b># Days on Site</b>	<b>Daily Hours on Site</b>
	Physician				
	Physician's Assistant(s)				
	Nurse Practitioner(s)				
	Nurse(s)				
	LPN(s)				
	Counselor(s)				
	Clinic Supervisor				
	Pharmacist(s)				
	Other				
<b>N.</b>          <b>Responsiveness to Community Concerns</b>	Describe below the applicant's plans to assure the smooth integration of services in the community. Include in the description the measures to be employed to address patients who loiter in the clinic neighborhood after receiving clinic services.				
<b>O.</b>          <b>Treatment Services</b>	Describe treatment services in detail. This description supplements the description of treatment services previously covered in Section D. <b>Important: Subject matter to be covered is listed in the instructions.</b>  <i>Include as ATTACHMENT #20 a description of treatment services.</i>				