NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Chemical Dependence Certification Application Instructions (PPD-5)

07/13/16 (Revised)

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Chemical Dependence

Certification Application Instructions

Background Back to Table of Contents

An existing or prospective provider of substance use disorder services is required to obtain the prior approval of the Commissioner of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) before establishing, incorporating and/or constructing a facility or offering a service.

Application Process Back to Table of Contents

The first step in the certification application (application) process is for prospective applicants (i.e., proposed new or existing providers of chemical dependence services) to contact the Local Governmental Unit (LGU) and the OASAS Field Office (FO) in the jurisdiction where services are to be offered to arrange for a discussion of the conceptual basis for the application and its relationship to the service needs expressed in the LGU's Local Services Plan (if applicable). These discussions are required and prospective applicants must complete the Certification Proposal – Prior Consult Form (**Attachment #1A**) and submit it with the application submission. At the conclusion of these discussions, the FO and LGU will render a recommendation on the applicant's proposal.

The only actions that do not require a Certification Proposal Prior Consult Form - Attachment #1A are:

- **Minor Relocations**;
- **Capital Projects**;
- **Add a Supportive Living Site (PPD-11); and,**
- **Changes to Prevention Sites (PPD-14).**

The instructions have been developed to assist applicants in the completion of the application. Applicants are strongly encouraged to read these instructions before completing the application. The instructions:

- explain the various parts of the application;
- identify the specific parts of the application to be completed based on the action(s) being pursued by the applicant;
- describe the appropriate response requirements for each item of information requested;
- describe the various items of documentation to be submitted as Attachments; and
- eliminate delays in the review process that result from incorrect, incomplete or unclear responses.

The Certification Application (PPD-5) is comprised of the following components:

1. Application Summary
2. Part I - Entity Information
3. Part II - Site Information
4. Part III - Description of Services
5. Part IV - Resource Allocation
6. Part V - Service Capacity Increases or Transfer of Ownership
7. Appendices

    Appendix I - Governing Authority Questionnaire
    Appendix II - Staff Deployment Matrix (Outpatient Treatment Services w/Additional Locations)
    Appendix III – Minor Relocations
    Appendix IV – Character and Competence Applicant Review
    Appendix V – Justice Center - Criminal Background Check.

OASAS requires the applicant to submit one signed original application and one signed copy to the NYS OASAS, Bureau of Certification and Systems Management, 1450 Western Avenue, Albany, NY, 12203-3526. In addition, one signed copy of the application must be sent to the OASAS FO and one signed copy to the appropriate LGU.

The type of action(s) being pursued by the applicant determines the components of the application that need to be completed. Figure 1 identifies the action category, the specific action, and the corresponding components of the application that will need to be completed. Each component requires one or more Attachments that must also be submitted with the application. **Incomplete applications will be returned to the applicant.**

Figure 1 – Components for Proposed Action(s) Back to Table of Contents

Action Category	Specific Action Requiring OASAS Approval	Part of Application to be Completed										
		Summary	Part I	Part II	Part III	Part IV	Part V	Appendix I	Appendix II	Appendix III	Appendix IV	Appendix V
New OASAS Provider	Newly created entity or an existing Non-OASAS entity to provide treatment services.	X	X	X	X	X		X			X	X
	To assume ownership of an existing OASAS-certified treatment service by a non-OASAS certified entity.											
New Sponsor	To assume governing authority of an existing OASAS-certified treatment Service by a non-OASAS certified entity.	X	X					X			X	X
New Treatment Service	Existing OASAS-certified provider opening a new treatment service or services at a site that is not dependent on or subordinate to another site.	X		X	X	X						
Capacity Increase	An existing OASAS-certified provider increasing the capacity of treatment services at a site where such services are currently authorized.	X		X		X	X					
Minor Relocation	An existing OASAS-certified provider relocating certified treatment services to a new site in accordance with stipulated criteria in Appendix III in these instructions.	X		X						X		
*Relocation	An existing OASAS-certified provider relocating certified treatment services to a new site, that does not meet the criteria for a "minor relocation" as defined in Appendix III in these instructions.	X		X								
Space Expansion	Adding space to a certified site.	X		X		X						
Additional Location	An existing OASAS-certified provider opening an additional location that is dependent on and subordinate to a site that provides certified outpatient treatment services. The additional location must be contiguous to the main site.	X		X	X	X			X			
Merger	Merge between existing OASAS-certified providers. If services, budget and staffing remain the same, omit Parts III, IV and V and include a statement to that effect.	X			X	X	X					

Action Category	Specific Action Requiring OASAS Approval	Part of Application to be Completed										
		Summary	Part I	Part II	Part III	Part IV	Part V	Appendix I	Appendix II	Appendix III	Appendix IV	Appendix V
Transfer of Ownership	Transfer ownership of existing certified treatment services to another existing OASAS-certified provider of certified services.	X			X	X	X					
Capital Project	Approval to make a capital investment in a facility where certified treatment services are (or will be) provided.	X		X								
Change in Ownership	Approval for an existing OASAS provider of certified services to change its ownership by: a transfer, assignment or other disposition of 10% or more of the stock, voting rights or membership interest in a business corporation or limited liability company, as appropriate, or a transfer, assignment or other disposition of stock, voting rights or membership interest in a business corporation or limited liability company, as appropriate, that results in a change in the ownership of more than 10% of the stock, voting rights or membership interest, or a change in the principals involved in the ownership of an individual proprietorship, partnership or limited liability partnership.	X	X					X			X	X

X - Mandatory completion required in accordance with instructions for the specific action for which the applicant is seeking approval.

NOTE: In cases involving multiple actions, the action that requires completion of the largest number of mandatory components governs application completion requirements.

* If the proposed relocation affects the current operating budget or capacity, the applicant ***must*** include Part IV Resource Allocation with the application. If the proposed relocation does not affect the current operating budget or capacity, the applicant should attach a statement to that effect.

Please Note: The only actions that do not require a Certification Proposal Prior Consult Form - Attachment #1A are:

- **Minor Relocations**;
- **Capital Projects**;
- **Add a Supportive Living Site (PPD-11); and,**
- **Changes to Prevention Sites (PPD-14).**

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The instructions follow the order of items appearing on each page of the application. The applicant should contact the OASAS FO or the Bureau of Certification and Systems Management (BOC) for clarification, if necessary. The BOC can be contacted by calling (518) 485-2250 or by e-mail at Certification@oasas.ny.gov.

Application Instructions

Application Summary Back to Table of Contents

The Application Summary is required for all proposed actions identified in Figure 1 of the instructions.

- **Attachment #1A –** The Certification Proposal – Prior Consult form must be completed and included with the application as proof of prior consultation with the LGU and FO. **The application will be returned if Attachment #1A is not submitted.**

- **Applicant's Legal Name**

  Enter the applicant's legal name as it appears on the legal documentation establishing the entity, i.e., incorporation papers, partnership agreement, legal resolutions, etc. The legal name entered on the form ***must*** be identical to the name appearing on the legal documentation. Please note that the application cannot be accepted if the legal name does not ***exactly*** correspond to the legal documentation for establishment submitted with the application.

- **Entity Administrative Headquarters Mailing Address**

  Enter the complete mailing address of the entity's administrative offices.

- **Summary of Application**

  Check the appropriate category and provide a brief summary of the purpose for submitting this application.

- **Certifications and Assurances**

  Under penalty of perjury, the following signatures are affixed, where appropriate, to certify and assure that:

  1. a. **Authorization to Represent Applicant** – For Corporate Entities, include as **Attachment #1** a signed and dated corporate resolution authorizing the contact person identified on Page 2 of the Application Summary to act on its behalf in the preparation of this application and to represent the applicant throughout the certification application process. If not a Corporate Entity, the Owner(s) must include a signed and dated statement authorizing the contact person to act on their behalf in the preparation of this application and to represent the applicant throughout the certification application process.

  1. b. **Authorization of Proposed Action** – For Corporate Entities, include as **Attachment #2** a signed and dated corporate resolution authorizing the proposed action. If not a Corporate Entity, the Owner(s) must include a signed and dated statement authorizing the proposed action.

  2. **Certification of Finder's Fee and Other Considerations** - The applicant certifies, as represented by the signatory principal of the governing authority or authorized representative, that the applicant has not paid or offered, or will not pay or offer, a fee or any other consideration for referrals to the services to be provided by the applicant.

  3. **Assumption of Financial Risk – Non-OASAS Funded Applicants Only** - The applicant will assume (or will

continue to assume) any and all financial risk in the development and/or operation of the services proposed in the application and verifies/certifies that sufficient financial resources are available for the start-up and/or continuing operation of such services described, and will not seek OASAS funding for these services under the circumstances described in the application. This certification applies ***only*** to applicants that are ***not*** seeking OASAS funding.

4. **Certifications by a Principal of the Governing Authority** - The applicant, as represented by the signatory principal of the governing authority, agrees to comply with operational requirements in accordance with an Operating Certificate (OC), including the requirement not to provide services in the absence of an OC and that the information contained in the application is accurate, true and complete in all material aspects.

- **Applicant's Legal Name**

  Enter the applicant's legal name as entered on Page 1.

- **Application Contact Person**

  Identify the individual selected by the applicant to be contacted regarding the information contained in the application. The information must include the contact person's telephone, fax number, and e-mail address. The contact person identified on Page 2 must be the same person identified in the Board Resolution or Owner's statement. Any change regarding the contact person must be submitted to the BOC in writing.

- **Local Support**

  Include as **Attachment #2A**, a description and proof of your outreach efforts to the local community (e.g., Community Service Boards, Community Boards, Planning Boards, Neighborhood Coalitions, other local municipalities). Please summarize community input, including any existing or likely community concerns, as well as any recommendations. Include date(s) and the name(s) of the local community official(s).

- **Proximity to Nearest Community Facility/Type of Facility**

  Enter the proximity (miles) to the nearest community facility (e.g., school, religious center, child care facility, etc.) and indicate the type of facility.

- **Identification of Sites and Services Affected by this Application**

  If the proposed action is for a "**Change in Ownership Status"** only, the applicant should select "**None"** and proceed to the next applicable component. If "**As Detailed Below**" is selected, the applicant should list only those sites and related services that are the subject of the actions identified in the Application Summary. The applicant should not list sites and services unaffected by the application. Space is provided on the application for up to three sites. Attach additional sheets, if necessary.

  Specific items in each site block are completed as follows:

  Site Address

  Enter the site address, if any. **Only new providers** may select "**Not Yet Selected**" if the address of the new site is undetermined at the time the application is submitted. Existing providers ***must*** provide the site address at the time of submission of the application.

  Services

  List the services to be provided at each site. Use the specific regulatory designation for each service.

  Status

Select the appropriate box to designate the status of the service:

- "New" if the service is not operational; or
- "Existing" if OASAS has issued a current OC for the site authorized for this service.

Persons Served

Enter the unduplicated count of individuals who will receive the service annually, when fully operational.

Capacity

Enter the current and proposed capacity of the existing and proposed service, as appropriate. For new services, enter "0" as the current capacity. Generally, capacity is not an attribute of outpatient chemical dependence treatment services.

Units of Service

Enter the current and proposed units of service of existing and proposed services. For new services, enter "0" as the current Unit of Service

OASAS Certificate Number

For each service, enter the current OC number assigned by OASAS to that service at that site (last 5 digits only). This does not apply for "new services".

Part I – Entity Information Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

A. Applicant's Legal Name

Enter the applicant's legal name **exactly** as it appears on the legal documentation establishing the entity, i.e., incorporation papers, partnership agreement, legal resolutions, etc. If applicable, enter the applicant's "Proposed Name". Include any "doing business as" (dba) name(s) for each, if applicable. If the application is modifying the powers of an existing entity to provide certified chemical dependence treatment services, then use the "Current Name" space. If an existing provider is changing its legal name, then complete both sections on the form.

B. Type of Entity

Select the appropriate current entity type. Select the appropriate proposed entity type. If the applicant is seeking to establish a new entity, enter the information in the "Proposed Entity Type" section of the form only. If the applicant seeks to modify the powers of an existing entity to provide chemical dependence treatment services, then complete the "Current Name" section on the form. If an existing provider is changing the type of entity under which it operates as required by Title 14 NYCRR Part 810, then complete both the "Current Entity Type" and the "Proposed Entity Type" sections of the form.

All applicants must include as **Attachment #3** appropriate establishment or proposed establishment documentation as specified in **Exhibit A** of these instructions.

Corporate Entities

Section 32.31 of the Mental Hygiene Law, Section 406 and Section 407 of the Business Corporation Law and Section 404(u) of the Not-for-Profit Corporation Law require OASAS approval of any Certificates of Incorporation, or Amendment thereto, which has among its purposes the establishment or operation of any facility proposing to provide chemical dependence, alcoholism or substance abuse services or to solicit contributions for any such purpose.

OASAS has made the process for obtaining approval of amended incorporation documents coincide with the process for obtaining OASAS approval for the provision of certifiable chemical dependence services through the application. Upon receiving OASAS consent to file, the amended incorporation papers are forwarded by the applicant or the applicant's representative to the New York State Department of State for filing, except in the case of not-for-profit entities that also require approval from the Justice of the Supreme Court of the Judicial District in which the corporate offices (will) reside, prior to filing with the Department of State.

OASAS requires that corporate entities include the following statement of purpose in their amended incorporation papers:

> **"To operate chemical dependence, alcoholism and/or substance abuse services, within the meaning of Articles 19 and 32 of the Mental Hygiene Law and the Rules and Regulations adopted pursuant thereto as each may be amended from time to time, which shall require as a condition precedent before engaging in the conduct of any such services an Operating Certificate from the New York State Office of Alcoholism and Substance Abuse Services."**

C. Entity Identification

OASAS Provider #

Enter the unique five-digit number assigned by OASAS to each provider of chemical dependence services. Applicants who are new entities to OASAS should leave this item blank; OASAS will assign a Provider # when the OC is issued in conjunction with the issuance of instructions for reporting client data.

Social Security # or Employer Identification # (EIN)

Enter, as appropriate, the Social Security # or the Employer Identification # (EIN) of the individual or other entity under which federal tax returns are filed.

NYS Charities Registration #

Applicants that are not-for-profit entities are also required to submit information and documentation regarding their registration or exemption as a charitable entity and tax exemption status. Enter the NYS Charities Registration #. If exempt, select "Exempt." Include as **Attachment #4** a copy of the letter of registration or the letter of exemption received from the State of New York.

Tax Exemption Status

Include as **Attachment #5** the most recent letter from the Internal Revenue Service documenting the tax-exempt status of the not-for-profit entity.

D. Entity Licenses, Certifications and Accreditations

Select the organizations from which the applicant holds licenses, OCs, accreditations or other comparable credentials. List non-New York State credentials, if any, in "Other". Include as **Attachment #6** a copy of all current licenses, OCs, accreditations and/or other comparable documents.

E. Entity Experience in Chemical Dependence Services

As outlined in Part 810 – Certification of Providers of Chemical Dependence Services of the OASAS Operating Regulations, specifically Section 810.7(a)(6), owners or principals of the applicant must demonstrate and substantiate prior experience providing or managing substance use disorder treatment services. Include as **Attachment #7**, the identification of the owners/principals listed in Part 1, Section F, who have prior experience in providing chemical dependence services, including alcoholism and substance abuse services, along with other human services, and a brief description of their experience. Include with **Attachment**

#7 a copy of the applicant's most recent annual report.

F. Entity Governing Authority and Principal Stockholders (Non-Governmental Entities Only)

Provide a complete listing of all current members of the applicant's governing authority, the individual or group of individuals responsible for policy formulation and operational oversight. This may exist as an executive committee, board members, directors, or other governance body. For applicants that are business corporations, also list each non-governing authority shareholder controlling 10 percent or more of the corporation's stock. List each individual's name (first, middle initial, last), designate the individual as "M" for governing authority member or "S" for principal stockholder, as appropriate, and list the individual's social security number or employer identification number, as appropriate. For applicants that are business corporations, enter the number of shares of stock, distributions, and/or voting rights held by each member or principal stockholder; and the percentage held for the preceding by each member or principal stockholder. If none, enter "0."

Each governing authority member/principal stockholder listed must complete, sign and date the Governing Authority Questionnaire (**Appendix I**).

Part II – Site Information Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

A. Address of Existing/Proposed Site

Enter the complete address of the existing or proposed site. Please note that a Post Office Box alone is insufficient; a street address is required for patient use as well as for OASAS program reviews and/or inspections. If a proposed site has not yet been identified, select "**Not Yet Selected**" **(new providers only**) and proceed to the next item. If you are adding an additional location, enter the main site address in this section of the form.

Please note that the address requires the completion of items related to NYS Assembly District, NYS Senate District, Congressional District and, in New York City only, the NYC Community Board Number. If this geopolitical data is not known, the applicant can obtain it by contacting the State Board of Elections. Leave these items blank if a site has not been selected.

B. Action Proposed

Select the box that most accurately describes the action for which the applicant is seeking approval for this site:

- increase in the physical size of the existing site where certified treatment services are provided - select the "**Expand an Existing Site**" box and proceed to Section D;
- provide full-time certified treatment services in a new location, while maintaining existing services at other authorized sites - select the "**Establish a New Site**" box and proceed to Section D;
- relocate its full-time certified treatment services or an additional location to a new location, **other than a minor relocation** (see **Appendix III**) - select the "**Relocate to Another Site**" box and proceed to Section D; or
- establish certified outpatient treatment services at a location that is to be dependent on the staff and facilities of the site identified in Section A - select the "**Establish an Additional Location Associated with the Above Site**" box and proceed to Section C.

C. Address of Additional Location

Enter the complete address of the proposed Additional Location, as appropriate. A Post Office Box alone is insufficient; a street

address is required for patient use as well as for OASAS program reviews and/or inspections.

Please note that the address requires the completion of items related to NYS Assembly District, NYS Senate District, Congressional District and, in New York City only, the NYC Community Board Number. If this geopolitical data is not known, the applicant can obtain it by contacting the State Board of Elections. Leave these items blank if a site has not been selected**.**

D. Property Acquisition

Select the appropriate status describing the means (to be) used to acquire the Site or Additional Location where services are (to be) provided. If "**Currently Owned by Applicant*"*** is selected, proceed to Section F. If "**Currently Leased by Applicant,"** "**Proposed Purchase,"** or "**Proposed Lease"** is selected, include as **Attachment #8** the following documentation:

- a copy of the proposed purchase offer agreement/sales contract, if purchase is pending; or
- a copy of the existing or proposed lease; pursuant to Section 810.7 (d), the lease agreement ***must*** contain the following clause:

> "*The landlord acknowledges that the rights of re-entry into the premises as set forth in this lease do not confer on the landlord the authority to operate an alcoholism, substance abuse, or chemical dependence facility. The landlord agrees to give the New York State Office of Alcoholism and Substance Abuse Services at least thirty days notice by certified mail of an intent to re-enter the premises or to initiate dispossess proceedings and at least sixty days notice of expiration of the lease*."

E. Source of Funds to Finance Purchase or Lease

Indicate the source(s) and dollar amount(s) required by the applicant to purchase or lease the Site/Additional Location. This amount does not include the cost of construction or renovations required, unless, in the case of a lease, the landlord has agreed to finance the cost of the renovations and recoup those costs through the lease.

F. Real Property Interest of Applicant in Proposed Site/Additional Location

Select the appropriate box(es) to indicate any direct or indirect interest held by the following in the land, building(s) or equipment at this Site/ Additional Location:

1. the applicant's governing authority members, officers, stockholders or employees;
2. any relative of the applicant's governing authority members, officers, stockholders or employees;
3. any other entity of which the applicant's governing authority members, officers, stockholders or employees are a member; or
4. not applicable.

If Item #1, #2, or #3 is checked, provide in **Attachment #9** the name, address and relationship to/affiliation with the applicant and a description of the nature of the real property interest held by the each individual or entity listed.

The purpose for requesting this information is to determine if such relationship is less than arms-length and that the cost of the purchase or lease does not exceed market value or provide the individual or entity with an extraordinary financial gain.

G. Capital Investment Needs of Property

This section of the application describes the need for capital investment at the identified site or additional location, including construction, renovation, rehabilitation or other capital investment that extends the useful life of the facility and makes it safe and suitable for the provision of chemical dependence treatment services.

Select the appropriate response to signify the need for capital investment at this site/additional location.

1. If "No", proceed to Section I.

2. If "Yes",

   a) complete **Attachment #10** which describes the construction or rehabilitation work (to be) completed, including, where applicable, the size of the structure in gross square feet and the area(s), in square feet, (to be) used for the delivery of services. The description should address all major items needed to ensure that the structure is in compliance with OASAS facility standards, other OASAS regulations and standards, and all other relevant local codes and laws. The description should address accessibility, egress, fire ratings, size and proposed use of rooms and other areas used for service delivery. If the project is not completed, include an estimate of the time required to complete the following phases of the capital project: Site acquisition, schematic design, working drawings, project bid, award of contract(s), completion of construction, and inspections and approvals.

   b) indicate how this capital project was (will be) financed, as follows:

      - select "Capital Financing By the Applicant" if the project was (will be) financed through sources available to the applicant; then proceed to c. and d. below.
      - select "Cost (to be) Financed by the Landlord and Recovered through the Lease" for landlord-financed renovations; then proceed to Section I.

   c) select the appropriate response to indicate if the capital project requires or will require a new, amended or temporary Certificate of Occupancy.

   d) select the appropriate response to indicate the status of the capital project.

      (1) If "No" indicate the applicant's choice regarding completion of Section H.

      (2) If "Yes", proceed to Section H.

H. Capital Financing Requirements for Site/Additional Location

1. **Project Architect/Engineer -** Enter the name, address and telephone number of the architect or engineer selected by the applicant to carry out the planned capital project.

2. **Capital Project Cost -** Enter the estimated/actual cost of the capital project by category of expense; include the following costs in each category:

   - Site Acquisition - the purchase price of the land or buildings;
   - Construction/Renovation - costs associated with construction expense to be incurred by the contractor;
   - Design - costs of architects/engineers for professional design services;
   - Equipment - costs for fixed equipment and furnishings;
   - Other *(*Specify*)* - costs associated with construction supervision, legal fees, construction financing costs, (e.g., bank fees, bank appraisals, construction period interest, environmental studies, title and recording fees, other related costs, site security) accounting/auditing fees, insurance, site surveys, soil surveys, other surveys; and
   - Total Estimated Cost - the sum of the preceding costs.

3. **Sources of Capital Project Financial Support** - Indicate the source(s) and amount(s) provided to the applicant to finance the capital project.

4. **Proposed Construction Start Date** - If known to the applicant, indicate when the construction will begin; otherwise, indicate "Unknown."

I. Site Drawing and Photographs

Select the appropriate response that describes the need for OASAS approval of the Site or Additional Location as follows:

- Select Item a. if the applicant has not received OASAS approval for the provision of chemical dependence treatment services at this Site or Additional Location.
- Select Item b. if the applicant seeks approval for structural and/or floor plan changes to a Site or Additional Location that was previously approved by OASAS.
- Select Item c. if this application does not involve structural and/or floor plan changes for this Site or Additional Location.

If Item a. or b. is selected, include as **Attachment #11** each of the following for this Site or Additional Location:

- general site drawings detailing the dimensions and approximate location of the existing building(s) in relation to: property boundaries, existing roads, access drives, walks, well(s) and septic system(s), if applicable;
- floor plan sketches to scale (1/8") detailing: the existing building layout and the proposed building layout, with overall dimensions; room designations; maximum permitted occupancy; location of smoke detectors, fire alarm pull-boxes, telephones, sprinkler/standpipe systems, fire extinguishers, emergency lights and major appliances/equipment; and the direction of door swings. The sketches must identify sanitary facilities including: the number of sinks, showers/tubs and toilets per room; if the facilities are to be used by clients and/or staff, men and/or women; and are accessible to the physically disabled; and
- photographs of all sides of the outside structure which show the overall building condition, egress, surrounding area, etc.

  Please note, floor plans must be legible and of good quality. The application will be returned without further review if the floor plans are deemed unacceptable.

J. Setting for Site or Additional Location

Select among the choices listed, the setting that best describes where the Site or Additional Location is or will be situated:

- **Community** - a facility at which the only services provided are chemical dependence treatment services;
- **Hospital – On Premises -** a facility licensed by the NYS Department of Health as a hospital at which both chemical dependence treatment services and general hospital services are provided.
- **Hospital – Off Premises** - a facility licensed by the NYS Department of Health as part of a hospital but not on the grounds of the main hospital at which chemical dependence treatment services are provided either with or without general health services.
- **Federally Qualified Health Center (FQHC)** – a facility designated by the US Department of Health and Human Services (HHS) as an FQHC located in medically underserved areas that provide high quality, cost effective health care to anyone seeking care. Designation is location and service specific. Facilities are licensed by NYS Department of Health and proof of FQHC designation must be provided to the NYS Department of Health.
- **Other Health** - a facility, other than a hospital, licensed by the NYS Department of Health at which chemical dependence treatment services are provided either with or without general health services.
- **Mental Health** - a facility at which chemical dependence services are provided with services licensed by the NYS Office of Mental Health (OMH).
- **OCFS Facility** - a juvenile correctional facility operated by the NYS Office of Children and Family Services where chemical dependence treatment services are provided.
- **School** - an educational facility licensed by the NYS Education Department, either publicly or privately funded, where individuals receive chemical dependence services on school premises.
- **Shelter** - a discrete facility that provides emergency housing to persons who are homeless.
- **Shelter Plus Care Housing** - a facility that is part of a federally funded program of housing assistance specifically targeted to homeless persons with disabilities and their families. For programs administered by OMH and/or OASAS,

"persons with disabilities" are persons who are seriously mentally ill and/or have chronic chemical dependence problems.

- **Other** - a facility, other than any of the facilities described previously, where chemical dependence treatment services are provided. Specify the facility.

K. OASAS Physical Plant Inspections

Indicate if the site has received a physical plant inspection by OASAS. If "Yes", indicate the date of the most recent inspection, as indicated on the OASAS Facility Inspection Report, and proceed to Part III. If "No", proceed to Section L.

L. Shared Space Issues

Indicate if the applicant will share space with other providers of human services. If "Yes", describe in the space provided plans to assign discrete space for chemical dependence services as well as plans for utilizing shared space (e.g., through scheduling, etc.).

M. Property Characteristics

Complete Items 1 - 7 below which describe the characteristics of the facility.

1. **Structure** - Select the appropriate box describing the structure of the building. Specify any structure indicated as "Other".
2. **Exterior Walls -** Select the appropriate box describing the materials used for the exterior walls of the building. Specify any materials identified as "Other".
3. **Foundation** - Select the appropriate box describing the materials used for the foundation of the building.
4. **Building** - Select the appropriate box describing the building. Also indicate the number of floors (excluding basement) in the building.
5. **Basement** - Indicate if the building has a basement. If "Yes", indicate if the basement will be used for service delivery. If "Yes", indicate the size of the basement in square feet.
6. **Area(s) (to be) Used for Service Delivery** - For each floor (to be) used for service delivery, indicate the amount of square feet (to be) used for providing services and the number of exits located on each floor.
7. **Services/Utilities** - Select the appropriate box to indicate the type of water supply, sanitary systems, and power sources available to the building. Specify services/utilities marked as "Other".

N. Local Planning Requirements

Items 1 - 4 are intended to ascertain information from the applicant regarding the status of the Site/Additional Location relative to local planning and zoning requirements.

1. **Zoning Classification** - Enter the current zoning classification for the Site/Additional Location.
2. **Conformity with Classification** - Indicate if the proposed use of the Site/Additional Location conforms to the current zoning classification.
3. **Building Classification** - Enter the building classification attached to the building.
4. **Certificate of Occupancy** - Include as **Attachment #12** a copy of the Certificate of Occupancy, Temporary Certificate of Occupancy, Certificate of Compliance or Letter of No Objection. If not available, provide documentation from appropriate regulatory authority.

O. Area Characteristics

Describe the characteristics of the proposed site location and its surrounding buildings and land uses, public transportation, parking facilities, general traffic, etc. Indicate the availability of other chemical dependence and social services in the same building or in the immediate vicinity. Include location of nearest school.

P. Accessibility to the Disabled

Indicate if the facility has made reasonable accommodations for access by individuals with physical disabilities including access ramps, doorways, sanitary facilities, elevators, equipment, etc. If a "No" response is indicated, describe the arrangements planned or in place to serve the disabled, including any referral agreements with other chemical dependence or human services providers.

Q. Historical/Environmental Significance of This Site

Respond to Items 1 - 8 to assess the historical/environmental significance, if any, of the site/additional location.

R. Relocation Only

Indicate if the current operating budget or capacity will be affected by the proposed relocation. If yes, the applicant must complete and submit Part IV Resource Allocation with the application.

Part III - Description of Services Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

A. Action Proposed

Select the response that describes the action for which the applicant is seeking approval as follows:

a) Select "**Provide a New Service at this Site**" in cases where the applicant seeks approval to provide a new treatment service; proceed to Section B.

b) Select "**Establish a Service at an Additional Location**" in cases where the applicant seeks approval to provide services at an additional location stand-alone site (outpatient services only); proceed to Section B.

c) Select "**Establish a Service at an Additional Location at a Host Agency"** in cases where the applicant seeks approval to provide services at an additional location at a "host" agency. Complete **Attachment #13** that addresses the following subject matter:

- **Authorization of the Arrangement** - documentation appended to **Attachment #13** in the form of a resolution by the host agency's governing authority that authorizes the proposed services and authorizes the use of the host agency's resources by the applicant.
- **Alternatives** - a brief statement explaining the advantages of providing the proposed services at the host agency location rather than at a Site or stand-alone Additional Location operated by the applicant.
- **Consistency with Local Services Plans** - a statement providing assurance that the proposed services at the host agency (which typically serves a narrowly defined target population) will not diminish the applicant's ability to meet the needs of the general population in its service area. The statement should provide evidence that any State agency that certifies or otherwise authorizes the services provided by the host agency has been notified of and been afforded the opportunity to comment on (either at the time of application or in response to an OASAS request to the State agency) the time, place and circumstances under which the applicant seeks OASAS approval to utilize the host agency's resources.
- **Potential for Compliance with OASAS Regulations** - *a* copy of an agreement, appended to this Attachment, between the applicant and the host agency regarding arrangements to ensure compliance with all appropriate Federal confidentiality regulations by the host agency staff, and by anyone else having access to the proposed host agency location. This may take the form of a ***qualified service organization agreement*** or it may be specified in the space use agreement, mentioned below.

- **Space** - a space use agreement between the applicant and the host agency that, at a minimum, ensures the applicant exclusive use and control of the treatment space during the time that treatment is to be provided. This space agreement is in lieu of a standard lease.

B. Description of Area to be Served

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.

C. Assessment of Need

Provide an assessment of the need for the services requested. In addition to the assessment, use existing OASAS need methodology where available from the LGU. Include in **Attachment #14** the following information to support the assessment of need developed by the applicant:

- a description of the relationship of the proposed services to the applicant's long range service development plan;
- a chart or narrative describing the demographic characteristics of the area to be served including age, sex, ethnicity, level of disability;
- an assessment of the availability of similar services in the targeted geographic area;
- a description of how the applicant will address the special needs of disabled people;
- a description of the relationships and impact of the proposed services on the area's existing health care system and on its other support services;
- an assessment of the availability of resources (e.g., support services) needed to provide the proposed services;
- a description of the methodology used to determine need for the targeted service area accompanied with supporting calculations; and
- other data and/or information that supports the applicant's determination of need.

D. Description of Services

1. **Statement of Philosophy** - Provide a statement of the applicant's approach/philosophy regarding the treatment of chemical dependence, including use of self-help services, medication, individual/group counseling, negative reinforcement and other treatment techniques and methodologies.

2. **Description of Service Components** - Include as **Attachment #15** a defined list of service components that will be offered to patients, including any proposed time-structured treatment regimen or module. **Exhibit B** of these instructions provides a list of typical components of a chemical dependence service. OASAS strongly suggests that the applicant use **Exhibit B** as the format for identifying the service components that will make up the proposed treatment service. If **Exhibit B** is used, please label it as **Attachment #15**. The applicant should indicate if such service components will be provided directly or via some other means such as referral to another provider or by another service of the applicant. If any service component is to be provided by referral to another service provider, include with **Attachment #15** a copy of the formal written agreement(s) with the other provider(s).

3. **Planned Performance Measures** - Include as **Attachment #16** 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.

E. Special Populations

Select any of the special populations the applicant intends to target with these services. Specify any special population selected as "Other." Among the special populations identified are the following:

- ***No Special Population(s)*** - Used in instances where the applicant plans to serve the general public only,
- **W*omen*** - Adult female persons.
- **Pregnant Women** - Females with unborn fetus.
- **Women with Children** - Female drug and/or alcohol users who require services to include dependent children.
- **Youth** - Persons age 18 and under.
- **Elderly** – Persons age 55 and older.
- **HIV/AIDS** - Persons who are at risk for HIV/AIDS or are diagnosed as HIV positive.
- **MICA** - Persons who have a second DSM IV or most current version diagnosis in addition to a diagnosis of substance use disorder.
- **Homeless** - A person or family that is undomiciled, has no fixed address, lacks a regular night time residence, resides in a place not designed or originally used as a regular sleeping accommodation for human beings or resides in some type of temporary accommodation (e.g., hotel, shelter, residential program for victims of domestic violence, subway station).
- **Probation** - Persons sentenced to community supervision under the jurisdiction of any probation department in lieu of a jail sentence.
- **Parole** – Persons released from incarceration to community supervision under the jurisdiction of a Federal or State parole authority, in lieu of completion of jail time.
- **Alternative to Incarceration** - Persons who have been admitted to treatment as an alternative to being incarcerated for committing a criminal act. .
- **CASAT** - Inmates of New York State Correctional Facilities who participate in a chemical dependence treatment program operated by the Department of Correctional Services.
- **COSA/COA** - Persons who are children of drug and/or alcohol abusers who receive special services either with or without their parents. .
- **LGBT** - Persons whose chemical dependence is associated with their sexual orientation, sexual identity or gender issues.
- **Intravenous Drug Users (IDUs)** - Persons who inject drugs of abuse.

Describe any specific programmatic efforts that will ensure that services are provided to these groups.

F. Proposed Operating Schedule

Complete the table reflecting the applicant's planned operating schedule. If the service will operate 24 hours per day, seven days per week, select the box in the heading, in lieu of completing the full schedule. For an opioid treatment service, also indicate the hours that medication will be dispensed during regular operating hours.

G. Projected Workload

For applications seeking approval of Additional Locations, indicate the number of projected annual visits for the main location and the additional location. This data is requested to ensure that regulatory limits are recognized and observed by the applicant.

H. Operational Policies and Procedures

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. Guidance for writing policies and procedures can be found on the OASAS website. The applicant must develop and submit as **Attachment #17** detailed chemical dependence operational policies and procedures in accord with proposed services to be provided. (Omit for services at additional locations.)

For applications involving Medically Managed Withdrawal and Stabilization and Medically Supervised Withdrawal and Stabilization, the description of policies and procedures should include dosage levels based on patient condition, staff monitoring arrangements, medication storage and dispensing; clinical assessment/management of alcohol and substance-specific withdrawal syndromes; infection control; management or transfer of incapacitated patients; and a complete schedule for taking patients' vital signs, including the staff responsible, frequency and documentation requirements. List all substances from which patients are to be withdrawn; e.g., alcohol, opiates, cocaine, and/or sedative hypnotics, etc. and individual detoxification protocol for each listed substance. If methadone is to be used as a detoxification agent, complete Part III, Sections I - L.

NOTE: Sections I - O are completed for a new opioid treatment service.

I. Key Opioid Program Staff

List the names of key staff that will manage and administer methadone treatment services at this site.

J. Approval Status

Select the appropriate boxes to reflect the status of applications submitted to the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (CSAT), the Drug Enforcement Administration (DEA) and the NYS Department of Health (DOH), the other regulatory agencies with oversight responsibilities for opioid treatment services.

Include as **Attachment #19** a copy of each application submitted or other evidence that the approval process is in progress, or that approval has been granted.

K. Alternative Emergency Medication Procedures

1. Describe contingency arrangements to provide medication to patients in case of emergency or holidays when the clinic is unable to open.

2. Select the appropriate box indicating if these arrangements are consistent with CSAT Guidelines.

L. Methadone Security

Describe storage arrangements and security measures planned for opioid treatment services at this Site.

1. **Storage Arrangements** - Select the appropriate box to reflect planned storage arrangements and complete Item 2 or 3, as directed.
2. **On-Site Storage Security Measures** - Describe the alarm system and other security measures to be implemented for on-site storage of methadone.
3. **Off-Site Storage Security Arrangements** - Describe security measures for the transport of methadone to and from the central pharmacy location.

M. Staffing

Complete the table to reflect staffing of opioid treatment services. For "**# Days**" enter the number of days that the staff member will be on duty.

N. Responsiveness to Community Needs

Describe 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..

O. Treatment Services

Include as **Attachment #20** a description of treatment services to be provided. This description should not duplicate the description of services provided in Section D of Part III; rather, it should cover, but not be limited to, the following specific subject matter:

- preparation and formulation of methadone dosages, including identification of specific staff responsible for preparation and measures for insuring accuracy of dosages.
- procedures for and identification of specific staff assigned to supervise patient ingestion of methadone. .
- identification of other drugs to be used in treatment. .
- patient eligibility criteria for take-home medication privileges, including frequency of clinic visits. .
- urinalysis schedules and procedures. Include an explanation of how toxicology reports will be taken into account in the patient's treatment plan.
- any standards for successful completion of treatment beyond those described in Part III, Section D.
- schedules and procedures for the voluntary detoxification of maintenance patients.
- discharge detoxification procedures for patients who choose to leave treatment against medical advice.
- discharge detoxification procedures for patients who do not comply with the applicant's participation regulations. Describe in detail procedures to ensure compliance with OASAS opioid treatment regulations.
- a copy of the letter of agreement with the hospital that will provide inpatient detoxification, if applicable.
- a description of the clinical services planned to assess and respond to a patient's alcohol, cocaine and/or other chemical abuse/dependence problems.

Part IV – Resource Allocation Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

Note: If the proposed relocation affects the current operating budget or capacity, the applicant ***must*** include Part IV Resource Allocation with the application. If the proposed relocation does not affect the current operating budget or capacity, the applicant should attach a statement to that effect.

For Sections A-C, display expenses, revenues and resulting profit/deficit, if any, projected from operating the proposed service. **Fiscal data is required for the pre-operational period as well as the first full year of operations.** For Sections D-F, include information regarding assumptions used to develop expense and revenue data, and financial reports to demonstrate the financial condition of the entity.

A. Revenues

- **Client/Patient Fees** - Enter projected receipts from the clients/patients based on a fee schedule.

- **Temporary Assistance to Needy Families (TANF)** - Enter projected receipts from the Federal program that provides cash assistance to needy eligible families that include a minor child living with the parent or a caretaker relative. This is the successor assistance program to Aid to Families with Dependent Children (AFDC).

- **Safety Net Assistance (SNA)** - Enter projected receipts from the State program that provides cash assistance or vouchers to needy eligible persons that are not eligible for TANF and are not in sanction status.

- **Medicaid - Managed Care** - Enter projected receipts from managed care organizations (MCOs) as reimbursement for services provided to an individual eligible for Medicaid.

- **Medicaid - Fee for Service** - Enter projected receipts obtained in response to a claim submitted by the service provider to the New York State Medicaid payment contractor.

- **Medicare** - Enter projected receipts from the Federal program that provides reimbursement for services provided to eligible elderly individuals (65 or older).

- **Private Health Insurance** - Managed Care - Enter projected receipts for services rendered to an individual that is insured by an MCO.

- **Private Health Insurance** - Fee for Service - Enter projected receipts for services rendered to an individual by a health insurer that is not an MCO, as part of the health insurance benefit provided by an employer, union, or a commercial or not-for-profit insurer such as Blue Cross, Aetna, Metropolitan, etc. The benefits may be part of an individual or group plan.

- **Congregate Care Benefit Payments** - Enter projected receipts for residential treatment services rendered to an individual who is not eligible for Medicaid.

- **Federal Grants** - Enter projected receipts from Federal grants received directly by the provider in support of the services rendered. **Federal grants received through OASAS are excluded from this revenue category.**

- **State Grants** - Enter projected receipts from grant funds administered by New York State agencies, other than OASAS.
- **Local Government Grants** - Enter projected receipts from grant funds obtained from local governmental entities in support of the services rendered. This revenue category does not include local government funding provided as matching funds under OASAS net deficit financing provisions, pursuant to Article 41 of the Mental Hygiene Law.

- **Cash Donations From Closely Allied Entities** - Enter projected receipts from an applicant's closely allied entity (CAE), if any. A CAE includes but is not limited to a corporation, partnership, unincorporated association or other body formed to provide financial assistance for the benefit of the applicant entity.
- **Sale of Goods and Services** - Enter projected receipts from purchase of service agreements entered into by a provider.
- **Other Cash Resources** - List the source(s) and amount(s) of projected receipts from applicant fund raising (net receipts); personal donations/bequeaths; food stamps; the Federal school lunch, breakfast and milk program; investment income; interest on bank deposits; other revenue sources not identified above and in the preceding revenue categories.
- **Total Revenues** - Enter the sum of the preceding revenue categories.

B. Expenses

Enter the projected expenses by category as listed in Section B. List only cash expenditures; do not include "in-kind" expenditures, such as the value of donated space, equipment, supplies and materials and volunteer staff.

- **Personal Services (Salaries/Wages)** - Enter the projected cost, or portion thereof, that is **directly chargeable to** the **Service** (either direct or allocated), representing the salary/wages of full-time and part-time staff.
- **Personal Services (Fringe Benefits)** - Enter the projected cost, or portion thereof, that is directly chargeable to the Service (either direct or allocated), representing the fringe benefits of full-time and, as applicable, part-time staff. Such costs include, but are not limited to: the employer cost of social security, health/medical insurance, retirement, disability insurance, unemployment insurance, life insurance, workers' compensation, dental insurance, prescription drug and vision care benefits.
- **Consultants/Professional Services** - Enter the projected cost, or portion thereof, that is directly chargeable to the Service (either direct or allocated), of consultants to be employed by the applicant in the provision of services; e.g., the per diem charges associated with employment of an outside physician, psychiatrist or other specialized medical staff. In addition, include in this expense category the cost of accountants, auditors, legal services, information technology consultants or other professional services that are **directly** chargeable to the service.

- **Equipment to be Expensed by the Applicant** - Enter the projected cost, or portion thereof, that is directly chargeable to the

service (either direct or allocated), for equipment with a value of less than $1,000 or a useful life of less than two years that will be expensed, rather than depreciated by the applicant.

- **Property Expense** - Enter the projected cost, or portion thereof, of property expenses that can be directly charged to the service (either direct or allocated) including, but not limited to: rental/lease costs; building and grounds maintenance and repair expenses that maintain or restore a facility to its normal expected useful life; utilities such as electricity, heat, water, sewage system charges; leasehold/leasehold improvements which are the responsibility of the applicant under terms of the lease; mortgage interest; mortgage expenses; property and casualty insurance; and real estate taxes. Do not include depreciation expense.

- **Other Non-Personal Services Expenses** - Enter the projected cost, or portion thereof, that can be directly chargeable to the service (either direct or allocated), representing all other non-personal services expenses not accounted for in the preceding expense categories. Costs include, but are not limited to: food including dietary/food services contracts, meals and snacks; patient transportation; staff travel; staff training; supplies and materials, including medical supplies and materials related to the provision of services, including the cost of methadone; household/janitorial supplies; telephone and telecommunications; general liability, bonding and professional malpractice insurance related to the service; lease/rental of vehicles and/or equipment; postage and shipping; contractual services, including laboratory and urinalysis services, methadone registry expenses, and security services; garbage removal and snow removal. Do not include depreciation expense.

- **Allocated Provider Administration** - Enter the projected cost of management and general costs to be allocated to the service, as part of a recognized standard method of cost allocation. Include such items of expense as that portion of salary and fringe benefits of applicant management staff that are not directly allocable to the service; accounting/auditing/legal expenses; office supplies and materials; postage; organizational expenses; and all other non-personal services expenses associated with the administration and management of the applicant entity that cannot be charged directly to the service.

- **Total Expenses** - Enter the sum of the preceding expense categories.

C. Profit/Deficit

Enter the result from subtracting total expenses from total revenues. Enclose any deficit in parentheses.

D. Sources of Deficit Financing

OASAS State Aid - Enter the projected amount of **OASAS operational financial support, if any.**

Other Deficit Funding Sources - List source(s) and amount(s) projected to cover any deficit remaining after application of State Aid and local government funding if any.

E. Budget Assumptions

Include as **Attachment #21** the assumptions used to develop the pre-operational and annual operational budget for the proposed services. The assumptions should cover both expense and revenue estimates. Also include with **Attachment #21** any existing/planned rate schedule(s) and sliding fee schedules used in developing revenue estimates. Some areas to consider in developing assumptions are: estimates for site acquisition and ongoing site costs; staffing levels and phase-in; methodology for calculating projected Medicaid or other third party insurance revenues, expected utilization of services, etc.

F. Financial Condition of the Application

Include as **Attachment #22** a copy of the most recent annual independently audited financial statement/report. If no statement/report is available, include the most recent tax return and/or a pro-forma balance sheet (see **Exhibit D**). If the applicant has existed for less than one

year, indicate the type of statement/report available and attach all appropriate documents since the creation of the entity.

Examples of statements/reports that would be acceptable are:

- Independently Audited Annual Financial Statement
- IRS Form 990 (Not-for-Profit Entities Only)
- Entity Annual Financial Statements (Unaudited Balance Sheets and Income Statements).

Note: Newly created entities, all governmental entities and acute care general hospitals subject to Article 28 of the Public Health Law are exempt from completing this section of Part IV.

G. Staffing

Before completing this section, refer to the appropriate OASAS Operating Regulations to ensure the staffing pattern completed meets regulatory compliance.

Typical professions employed in each sub-group of the direct care staff category are listed at the bottom of the Part IV form, Page 2.

Complete each column as follows:

Actual Job Title

List, within the appropriate category and sub-group, the actual job titles to be assigned to provide the proposed services.

# of FTEs

Enter the number of full-time equivalent (FTE) positions to be assigned to each job title based on the number of hours (35, 37.5 or 40 hours) worked by a full-time employee in the standard work week of the applicant. A standard work week may not be less than 35 hours. A full-time staff member working a 40-hour standard work week is counted as 1 FTE; a part-time staff member working 20 hours at a site where the standard work week is 40 hours is counted as 0.5 FTE.

# of QHPs

Among the total FTEs, enter the equivalent number of staff who are qualified health professionals (QHPs) as defined in OASAS regulations.

Planned Staff Deployment

Indicate the number of staff to be assigned to each shift during the hours that the service is in operation.

H. Proposed Work Schedule

For each job title listed on Page 2, identify the proposed work hours as prescribed in regulatory standards (specify a.m. or p.m.).
For example:

H.	Proposed Operating Schedule													
	Is the proposed service open 24 hours per day, 7 days per week? ☐ Yes x No													
Job Title	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	From	To	From	To	From	To	From	To	From	To	From	To	From	To
Program Director	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.				
Counselor (CASAC)	9 a.m.	5 p.m.	9 a.m.	5 p.m.			1 p.m.	9 p.m.	1 p.m.	9 p.m.	8 a.m.	12 p.m.		
Counselor I			4 p.m.	8 p.m.	4 p.m.	8 p.m.	4 p.m.	8 p.m.	4 p.m.	8 p.m.	8 a.m.	12 p.m.		

Part V – Service Capacity Increases or Transfer of Ownership Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

A. Action Requested

Select the appropriate box to reflect the action requested. For transfer of ownership, enter the name of the provider from which the service will be transferred. For service capacity increases, proceed to Section B.

B. Service Capacity Increases

For each site, enter the current approved capacity for the service at this site, the requested capacity and the resulting increase in capacity.

C. Impact of Action

Select the appropriate boxes and enter other required information that describes the expected impact of the change on the space requirements, units of services and staffing of the service.

1. **Space** - Select the appropriate box indicating the impact of the requested action on space requirements at the site.
2. **Units of Service** – Select the appropriate box indicating the impact of the requested action on units of service. In cases involving increases in units of service, also enter the amount of increase expected.
3. **Staffing** - Select the effect of the requested action on FTE staffing. In cases involving increases in FTEs, identify the change. In addition, indicate the increases in FTEs by job title in the space provided. Attach additional sheets if necessary.

D. Financial Commitments

Select all appropriate boxes indicating the sources of financial support, if any, to cover the costs required for additional space and/or staff. Identify the specific sources of funding under "Other."

E. Issues Affecting this Action

Include as **Attachment #24** a narrative description that covers the following issues:

- the need for the increase in capacity or transfer of ownership;
- the availability of existing chemical dependence treatment services in the community and the effect of the requested increase or transfer of ownership on these existing services;
- the anticipated impact of the increase in capacity or transfer of ownership on the community; i.e., business, law enforcement, etc.; and
- the fiscal impact of the requested increase in capacity or transfer in ownership on operational factors, including an analysis of current and projected annual costs and revenues.

Prevention Services Subject to OASAS Certification Back to Table of Contents

Applicants seeking approval for prevention counseling services are directed to contact the OASAS Certification Bureau for appropriate application forms and instructions.

APPENDICES

APPENDIX I - GOVERNING AUTHORITY QUESTIONNAIRES Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

A completed **Governing Authority Questionnaire (Appendix I)** is required for each person listed in Part I, Section F - Entity Governing Authority and Principal Stockholders. It is used to assess the character and competence of the individuals who will provide oversight and exercise policy-making responsibilities on behalf of the applicant.

Individuals completing the Questionnaire are required, in the Questionnaire**,** to certify to the accuracy and truth of the information provided and to execute a release allowing OASAS to obtain verification/clarification from grantor agencies, educational institutions, employers, human services agencies and courts regarding the information provided.

APPENDIX II - STAFF DEPLOYMENT MATRIX - OUTPATIENT TREATMENT SERVICES WITH ADDITIONAL LOCATIONS Back to Table of Contents

Refer to Figure 1 of these instructions to determine if this component is required to be submitted for the proposed action(s).

Appendix II is used to demonstrate the planned deployment of staff FTEs for new outpatient services at sites that the applicant proposes to open Additional Locations.

The **Staff Deployment Matrix** provides space for four (4) Additional Locations. Use additional sheets for **Appendix II** for applications involving more than four Additional Locations per main site. Enter the address of each additional location at the bottom of the **Staff Deployment Matrix.**

For each affected site and service, enter the total number of FTEs for each job title and indicate the percentage of time assigned between the main location and/or additional location(s).

APPENDIX III – MINOR RELOCATIONS Back to Table of Contents

OASAS has implemented an expedited process for certain relocation applications. If the proposed relocation meets the following criteria, it is considered to be a “Minor Relocation”:

1. The request must not result in an increase in State Aid.
2. The request must be approved by the LGU (if applicable) and the OASAS Field Office.
3. The site proposed for the relocation must be in the same county or sub-county area, or in New York City, the same Community Board area, as the current site.
4. The provider must agree to treat the same target population at the proposed site.
5. The request must not propose an increase in capacity.
6. The request does not involve any type of construction and/or renovations to the new site.
7. The request must not propose services that are new or different from currently certified services.
8. The request must not be for a program regulated by another agency (e.g., DOH, DEA, OMH).

If the proposed relocation qualifies as a “Minor Relocation’ the applicant must ensure that the Appendix III – Minor Relocation form is

completed, signed by all required parties and included with the application submission. Refer to Figure 1 to determine which components are required to be submitted for a "Minor Relocation". If the applicant does not submit a completed Appendix III with the application, the Certification Bureau will process the application as a standard "Relocation". If the criteria for a "Minor Relocation" are not met, refer to Figure 1 to determine which components are required to be submitted for a proposed "Relocation".

A. Criteria Review

Review the criteria to determine if the proposed relocation falls under the purview of a "Minor Relocation". If yes, proceed to Section B. If not, refer to Figure 1 to determine the required components for submission of a Relocation application.

B. Address of Existing Program

Enter the complete address of the existing program. Complete all the address information requested.

C. Relocation Address

Enter the complete address of the proposed site. Complete all the address information requested.

D. Service Area of Existing Program

Enter the County, Sub-County area, or in New York City, the Community Board area of the existing program.

E. Service Area of Relocation

Enter the County, Sub-County area, or in New York City, the Community Board area of the planned relocation.

F. Target Population of Existing Program

Enter the target population for the existing program.

G. Target Population for Relocated Program

Enter the target population for the relocated program.

H. Services Provided in Existing Program

Enter the services that are provided at the existing program's site.

I. Services to be Provided in New Location

Enter the services that will be provided at the new site.

J. Operating State Aid for the Service(s) at the Existing Site

List the amount of State Aid listed on the State Aid Letter or contract, for the existing site.

K. Operating State Aid for the Service(s) for the New Site

List the amount of State Aid that will be needed at the new site**.**

L. Certificate Number(s) for this Location

List the OASAS certificate number for the existing site.

M. Active Program Reporting Unit (PRU) No.(s)

List the PRU number for the new site.

N. OASAS Provider Number

List the OASAS provider number

O. Brief Explanation of the Need for Relocation/Space Alteration

Briefly describe the reason(s) for the relocation.

P. LGU Approval

The applicant should meet with the LGU and FO to acquire their approval for the planned relocation. The LGU signs off on the bottom of the form.

Q. FO Approval

The applicant should meet with the LGU and FO to acquire their approval for the planned relocation. The FO signs off on the bottom of the form.

APPENDIX IV – Character and Competence Applicant Review Back to Table of Contents

The person completing this questionnaire must be knowledgeable about the Applicant's business and operations and must indicate if the questionnaire is filed on behalf of the proposed operator of an OASAS-certified facility or as a subsidiary of another business entity. Every question must be answered and each response must provide all relevant information which can be obtained within the limits of the law.

An owner or officer must certify this questionnaire and the signature must be notarized.

Specific instructions are included on the Appendix IV. Attach additional sheets if necessary, ensuring each response corresponds to the correct numbered question and includes the Applicant's legal name.

APPENDIX V – Criminal Background Check Back to Table of Contents

Effective June 30, 2013, all individuals applying to become a new OASAS certified provider of addiction treatment services are subject to a criminal background check, as required by New York State law.

If the applicant is a not-for-profit entity, the individuals who sign and/or submit the application are subject to the criminal history review. If the applicant is a for-profit entity, all individuals with an ownership interest are subject to the criminal history review.

The Certification – Applicant Consent Form for Fingerprinting for OASAS Criminal Background Check (TRS-54) ***must*** be completed and submitted with the application by applicants seeking OASAS approval for: 1) a new provider of chemical dependence services; or 2) a change in ownership status. For proprietary providers, any individual with ownership interest must complete the background check process. Not-for Profit entities must complete the background check process for every individual signing the application. An application received by the Bureau of Certification without the proper Criminal Background Consent form(s) will be returned.

Criminal Background Check Process

To begin the criminal background check process:

1. Visit the MorphoTrust website at www.identogo.com/ to schedule an appointment to have your fingerprints taken. To successfully schedule an appointment through the website, you will be asked to enter the following two numbers:

   - OASAS ORI Number – NY922287Z
   - OASAS Certification Provider Number – C9999

   Problems with the MorphoTrust website may be directed to **1-877-472-6915.**

2. Arrive at the fingerprint collection site at the time of your appointment and submit your fingerprints. You must provide two forms of identification. Information on acceptable forms of identification is available on the MorphoTrust website.

Important: There is a fee for the fingerprinting process. This fee will be paid to MorphoTrust at the time of your fingerprinting.

3. OASAS will be notified of your submission and will conduct your criminal history background check.

If you have a criminal history, we encourage you to **provide evidence of rehabilitation** and good conduct to assist OASAS' Counsel's Office with the review of your criminal history information. Examples of evidence of rehabilitation and good conduct include, but are not limited to, the following:

- Certificate of Relief or Certificate of Good Conduct;
- letters of recommendation;
- education achievements; and
- certificates of completion of treatment or rehabilitation programs.

Evidence of rehabilitation may be submitted to OASAS Counsel's Office by facsimile at (518) 485-2335 or by e-mail at cbc@oasas.ny.gov**. Please do not send this information to the Certification Bureau.**

Included with this packet is a copy of the "*Criminal History Background Checks Personal Criminal History Information Review"* which explains your right to obtain, review, and correct your criminal background history. Also included is a copy of Article 23-A of the Correction Law (page 32) which lists the factors that OASAS will consider when reviewing your criminal history.

Any further questions relative to the criminal background review may be directed to the OASAS Criminal Background Check Unit at: cbc@oasas.ny.gov.

PERSONAL CRIMINAL HISTORY INFORMATION REVIEW

NYS Division of Criminal Justice Services

Pursuant to 9 New York Code of Rules and Regulations Part 6050 the NYS Division of Criminal Justice Services (DCJS) an individual, or an individual's attorney who has been authorized in writing, may obtain either a copy of all criminal history information maintained on file at DCJS pertaining to himself/herself, or a response indicating that there is not criminal history information on file. The individual may also challenge the accuracy of the information through procedures established by DCJS. To obtain further information on the criminal history review process, please visit the DCJS website at: criminaljustice.ny.gov/ojis/recordreview.htm.

This section outlines the process for a prospective applicant to request a copy of NYS criminal history maintained by DCJS.

1. Contact MorphoTrust USA (formerly known as L-1 Identity Solutions) – a vendor under a state contract – by calling 1-877-472-

6915 (toll free number) or by visiting their website at www.identogo.com to schedule an appointment for fingerprinting.

2. The Request for MorphoTrust USA Fingerprinting Services – NYS Division of Criminal Justice Services Record Review Program" form describes the information that will be requested when you schedule the appointment.

3. In completing that information, please note:
   a. The Record Review ORI Number: NYDCJSPRY must be listed.
   b. You may request that your response be sent to your attorney rather than yourself.

4. When you arrive for your fingerprinting appointment, you must:
   a. Provide two forms of identification (information on acceptable forms are available on the MorphoTrust USA website or from the MorphoTrust USA Call Center; **and**
   b. Pay the fee for fingerprinting services using a personal or business check, certified check, bank check, money order, cash, or credit card made out to "MorphoTrust USA" or "L-1 Enrollment Services."

FBI Identification Record

The United States Department of Justice Order 556-73 establishes rules and regulations for the subject of an FBI Identification Record to obtain a copy of his or her own Record for review. Only the subject of the identification record can request a copy of his own FBI Identification Record for personal review or to challenge the information on the Record. The FBI's Criminal Justice Information Services (CJIS) Division processes these requests.

This section outlines the process for a prospective applicant to request a copy of their FBI Identification Record for personal review or to challenge information on the Record.

Requests for review of an FBI Identification Record must be mailed on signed cover letters provided by the FBI along with proof of identity (set of fingerprints) and payment to:

FBI CJIS Division – Record Request
1000 Custer Hollow Road
Clarksburg, West Virginia 26306.

To obtain all necessary information regarding these requests, visit http://fbi.gov/hq/cjisd/fprequest.htm

Challenging information contained on an FBI Identification Record, often referred to as a Criminal History Record or Rap Sheet, is a listing of certain information taken from fingerprint submission retained by the FBI in connection with arrests and, in some instances, federal employment, naturalization, or military service. If the fingerprints are related to an arrest, the Identification Record includes name of the agency that submitted the fingerprints to the FBI, the date of arrest, the arrest charge, and the disposition of the arrest, if known to the FBI. An individual may challenge the information contained in the FBI Identification Record by contacting the original agency that submitted the information to the FBI or the state central repository in the state in which the arrest occurred. These agencies will be able to furnish the guidelines for correction of the Record. The FBI is not authorized to modify the Record without written notification from the appropriate criminal justice agency.

Article 23-A – Licensure and Employment of Persons Previously Convicted of One or More Criminal Offenses

§ 750. Definitions.

For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

§ 751. Applicability.

The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§ 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.

No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

(1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or

(2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§ 753. Factors to be considered concerning a previous criminal conviction; presumption.

1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

   (a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

   (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

   (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

   (d) The time which has elapsed since the occurrence of the criminal offense or offenses.

   (e) The age of the person at the time of occurrence of the criminal offense or offenses.

   (f) The seriousness of the offense or offenses.

   (g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

   (h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§ 754. Written statement upon denial of license or employment.

At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§ 755. Enforcement.

1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

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ENTITY ESTABLISHMENT DOCUMENTATION

TYPE OF ENTITY	STATUS	ACTION	DOCUMENTATION REQUIREMENT
Individual Proprietor	New/Existing	Establish	• A copy of the Business Certificate (D/B/A) (to be) filed with the County Clerk or other municipal official.
		Acquire an Existing OASAS-Established Entity	• In addition to the above, a proposed contract of sale.
Partnership	New/Existing	Establish	• A copy of the new/existing partnership agreement. If appropriate, a copy of the Business Certificate (D/B/A) (to be) filed with the County Clerk or other Municipal official.
		Acquire an Existing OASAS-Established Entity	• In addition to the above, a proposed contract of sale.
Limited Liability Partnership	New/Existing	Establish	• A copy of the new/existing limited liability partnership agreement. If appropriate, a copy of the Business Certificate (D/B/A) (to be) filed with the County Clerk or other Municipal official.
		Acquire an Existing OASAS-Established Entity	• In addition to the above, a proposed contract of sale.
Business Corporation or Limited Liability Company	New	Establish	• An original of the Certificate of Incorporation (Certificate) for a Business Corporation or Articles of Organization (Articles) for a Limited Liability Company containing the required purpose statement. (See Page 2) The original of the Certificate/Articles must contain the signature(s) of the organizer(s), and the signature(s) must be notarized. If appropriate, a copy of the Business Certificate (D/B/A) (to be) filed with the Department of State.
	Existing	Amend	• A copy of the initial Certificate/Articles filed with the New York Secretary of State and any subsequent amendments to the Certificate/Articles that have been filed to modify the original Certificate/Articles. • A copy of the current Bylaws. • A notarized copy of the governing authority's resolution authorizing an Amendment to the Certificate/Articles which adds the authority to provide chemical dependence services, including alcohol and/or substance abuse services. The original of the proposed Certificate/Articles of Amendment containing the required purpose statement (See Page 2 of Exhibit B). • The original Certificate/Articles of Amendment must contain the signature(s) of the governing authority members authorized to file, and the signature(s) must be notarized.
	New/ Existing	Acquire an Existing OASAS-Established Entity	• In addition to the above, as appropriate, a proposed contract of sale.

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TYPE OF ENTITY	STATUS	ACTION	DOCUMENTATION REQUIREMENT
Not-for Profit Corporation	New	Establish	• An original of the Certificate of Incorporation containing the required purpose statement (See below). The original of the Certificate of Incorporation must contain the signature(s) of the incorporator(s), and the signature(s) must be notarized. In addition, the incorporation documents must include the following exclusionary clause: *"Nothing herein shall authorize this corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Section 404 (a-u) of the New York State Not-for-Profit Corporation Law except to the extent that such purposes or activities have been expressly approved via a Certificate or Consent to filing."* • If appropriate, a copy of the Business Certificate (D/B/A) (to be) filed with the Department of State.
	Existing	Amend	• A copy of the initial Certificate of Incorporation filed with the New York Department of State and any subsequent amendments to the Certificate that have been filed to modify the original Certificate. . • A copy of the current Bylaws. . • A notarized copy of the governing authority's resolution authorizing an Amendment to the Certificate which adds the authority to provide chemical dependence services, including alcohol and/or substance abuse services. • The original of the proposed Certificate of Amendment containing the required purpose statement (See Below). The original Certificate of Amendment must contain the signature(s) of the governing authority members authorized to file, and the signature(s) must be notarized. In addition, the Incorporation documents must include the following exclusionary clause, *"Nothing herein shall authorize this corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Section 404 (a-u) of the New York State Not-for-Profit Corporation Law except to the extent that such purposes or activities have been expressly approved via an Operating Certificate or Consent to File."*
	New/Existing	Acquire an Existing OASAS-Established Entity	• In addition to the above, as appropriate, a proposed contract of sale.
Public Agency	New/Existing	Establish/Amend	• A copy of the charter, law or resolution under which the agency was established; and any subsequent resolution which authorized a change in agency name or purpose

Recommended purpose statement to appear in incorporation papers:

"To operate chemical dependence, alcoholism and/or substance abuse services, within the meaning of Articles 19 and 32 of the Mental Hygiene Law and the Rules and Regulations adopted pursuant thereto as each may be amended from time to time, which shall require as a condition precedent before engaging in the conduct of any such services an Operating Certificate from the New York State Office of Alcoholism and Substance Abuse Services."

EXHIBIT B Back to Table of Contents

SERVICE COMPONENT INFORMATION

Service Component	Activities, Tasks And Procedures (Check all that apply)	Average Length of Session (Minutes)	Average Number of Sessions per Month	Service Provision Arrangements		
				On-Site By Applicant	Referral To Another Applicant Service	*Referral To Another Provider
Drug and Alcohol Counseling	☐ Individual Counseling					
	☐ Group Counseling					
	☐ Encounter Groups					
	☐ Family Counseling					
	☐ Family Group Counseling					
	☐ Stress Management Counseling					
	☐ Relapse Prevention Counseling					
	☐ Aftercare Counseling					
Vocational/ Educational	☐ Vocational/Educational Assessment					
	☐ Individual Vocational/Educational Rehabilitation Counseling					
	☐ Group Vocational/Educational Rehabilitation Counseling					
	☐ Work Readiness and Employability Skills Training					
	☐ Life Skills Training					
	☐ English as a Second Language					
	☐ Basic Education					
	☐ Remedial Education					
	☐ GED/HS Education					
	☐ College Preparation					
	☐ Vocational/Educational Job Referral and Placement					
	☐ Vocational/Educational Job Follow-up and Support					
	☐ Occupational Therapy					
	☐ Chemical Dependence Education					
Health-Related	☐ Acupuncture					
	☐ Detoxification					
	☐ Medical Examination					
	☐ Primary Medical Care					
	☐ Emergency Medical Care					
	☐ Nutritional Services					
	☐ Pre/Post Natal Care					
	☐ Pediatric Care					
	☐ HIV Antibody Testing					

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	Activities, Tasks And Procedures (Check all that apply)	Average Length of Session (Minutes)	Average Number of Sessions per Month	Service Provision Arrangements		
				On-Site By Applicant	Referral To Another Applicant Service	*Referral To Another Provider
Service Component	☐ Early HIV Primary Care					
	☐ HIV Case Management					
	☐ TB Testing					
	☐ TB DOTDOPT					
	☐ Health Counseling					
	☐ LAAM					
	☐ Antabuse/Naltrexone					
	☐ Psychotropic Medication					
	☐ Other Medication (Not Methadone or Psychotropic Rx)					
	☐ Urine Sampling					
	☐ Blood Drawing (Other than HIV)					
	☐ Breathalyzer					
	☐ Other Specialized Health Related Service					
Legal/ Criminal Justice	☐ Legal Counseling					
	☐ Legal Representation					
	☐ Reports to Court, DTAP, TASC, Etc.					
	☐ Reports to DMV's Drinking Driver Program					
Social Services	☐ Parent Training					
	☐ Activity Therapies					
	☐ Child Care					
	☐ Housing Assistance					
	☐ Recreation					
	☐ Entitlement Assistance					
	☐ Transportation					
Mental Health	☐ Individual Psychotherapy					
	☐ Group Psychotherapy					
	☐ Psychiatric Assessment					
	☐ Psychological Assessment					
	☐ Psychosocial Assessment					
	☐ Psychotropic Medication Management					
	☐ Psychiatric Crisis Intervention					
Case Management	☐ Formal Case Management					
	☐ Crisis Intervention					

*** ATTACH A COPY OF THE WRITTEN AGREEMENT BETWEEN THE APPLICANT AND THE OTHER PROVIDER.**

EXHIBIT C Back to Table of Contents

ATTACHMENT CHECKLIST

Component	Attachment #	Enclosed Yes	Enclosed N/A	Content
Summary	1	☐	☐	A signed and dated corporate resolution authorizing the contact person to act on behalf of the applicant in the preparation of the application and to represent the applicant throughout the certification application process. If not a Corporate Entity, the Owner must include a signed and dated statement authorizing the contact person to act on their behalf in the preparation of this application and to represent the applicant throughout the certification application process.
	1A	☐	☐	A copy of the Attachment 1A-Prior Consult form containing applicant, LGU and FO signatures. **The only actions that do not require a Certification Proposal Prior Consult Form - Attachment #1A are Minor Relocations**, **Capital Projects**; **Add a Supportive Living Site (PPD-11) and Changes to Prevention Sites (PPD-14).**
	2	☐	☐	If a Corporate Entity, a signed and dated corporate resolution authorizing the proposed action. If not a Corporate Entity, the Owner must include a signed and dated statement authorizing the proposed action.
	2A	☐	☐	Summary and proof of community outreach.
Part I	3	☐	☐	Appropriate entity establishment documentation as prescribed in **Exhibit A** of these instructions.
	4	☐	☐	**Not-for-Profit Entities Only:** A copy of the letter of registration as a charitable organization, or copy of exemption letter.
	5	☐	☐	**Not-for-Profit Entities Only:** A copy of the applicant's most recent IRS Tax Exemption Letter.
	6	☐	☐	A copy of all current licenses, operating certificates and/or accreditations.
	7	☐	☐	**Entities not Previously Certified by OASAS:** A brief statement of the applicant's previous history and experience in providing chemical dependence services and other human services.
Part II	8	☐	☐	A copy of the purchase offer/contract or existing/proposed lease for each affected site/additional location, if purchase or lease is contemplated.
	9	☐	☐	A listing including the name, address, and relationship to the applicant of persons, including governing authority members, officers, stockholders, or employees, or relatives of the foregoing, or other entities with which the foregoing are associated, who have a real property interest in the land, buildings and/or equipment at this Site/Additional Location and a description of the nature of the real property interest each person/entity has in such Site/Additional Location.
	10	☐	☐	Describe the work that was (needs to be) done to bring the property into compliance with OASAS facility standards, OASAS regulations and all local codes and laws. The description should address all appropriate issues identified in the instructions.
	11	☐	☐	For each affected Site/Additional Location, general site drawings, floor plan sketches to scale, and photographs of all sides of the outside structure as required in these instructions.
	12	☐	☐	A copy of the Certificate of Occupancy, Temporary Certificate of Occupancy, Certificate of Compliance, or Letter of No Objection. If not available, provide documentation from appropriate regulatory authority.

Part III	13	☐ ☐	A description, with required Attachments, of the arrangements and reasons for establishing an Additional Location at a host agency, addressing subject matter indicated in these instructions.
	14	☐ ☐	A Need Assessment for applicants that wish to present their own data for justifying the new services for which they are seeking approval.
	15	☐ ☐	A description of service components including, but not limited to, the tasks, activities and procedures listed in **Exhibit B**. For services (to be) delivered by another provider, a copy of each written agreement between the applicant and the other provider.
	16	☐ ☐	A statement of the measures of success to be used by the applicant to evaluate the effectiveness of the service.
	17	☐ ☐	Submission of a complete package of policies and procedures for the proposed service in accordance with proposed services to be provided.
	18		**Not currently applicable.**
	19	☐ ☐	**Applications involving New Opioid Treatment Services:** Copies of applications submitted to CSAT, DEA, and the NYS DOH or other evidence that the approval process involving these agencies is in progress or that approval has been granted.
	20	☐ ☐	A description of opioid treatment services covering the subject matter identified in these instructions.
Part IV	21	☐ ☐	A list of the assumptions used by the applicant in developing the expense and revenue estimates and copies of existing/planned rate schedules and sliding fee schedules as required in these instructions.
	22	☐ ☐	A copy of the most recent annual financial statement/report. If not available, a copy of the most recent tax return and/or a Fiscal Viability Information Form in the format prescribed in **Exhibit D**.
	23	☐ ☐	A job description for each job listed, including the duties and minimum qualifications in terms of pertinent training/ education and work experience.
Part V	24	☐ ☐	A description covering issues affected by an increase in service capacity or transfer of ownership of certified services between existing OASAS providers.

New York State
Office of Alcoholism and Substance Abuse Services

Service Provider Fiscal Viability Information Form
(Exhibit D)

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Service Provider Legal Name		Provider Number
Street Address		
City	State	Zip Code

PLEASE RESPOND TO ALL QUESTIONS

1. Organization's annual operating period: ☐ calendar ☐ fiscal year ending

2. Organization type: ☐ for-profit ☐ not-for-profit

3. If not-for-profit, is organization registered with the NYS Office of the Attorney General - Charities Bureau? ☐ Yes ☐ No

   If yes, what fiscal year was covered by the last annual financial report filed with the Office of the Attorney General – Charities Bureau?
   to

ATTACH A COPY OF THE LAST ANNUAL REPORT

4. Is an independent audit of the organization's annual financial statements conducted? ☐ Yes ☐ No

ATTACH A COPY OF AUDITOR'S REPORT AND AUDITED FINANCIAL STATEMENTS

5. If question 3 and 4 were answered "No" **ATTACH COPIES OF THE ORGANIZATION'S PREPARED ANNUAL FINANCIAL STATEMENTS (ENTITY-WIDE BALANCE SHEET AND INCOME STATEMENT), FOR THE LAST COMPLETED FISCAL YEAR.**

6. Complete an unaudited Entity-Wide Pro Forma Balance Sheet (see page 2 of this Form), **as of the most recent month end.**

7. Is the ratio of current assets to current liabilities, reflected in **either the audited balance sheet for the last completed fiscal year or the Entity-Wide Pro Forma Balance Sheet for the most recent month end,** less than .90 to 1.00 (minimum acceptable current ratio)? ☐ Yes ☐ No

(Example: current assets = $1,000; current liabilities = $2,000; current ratio = .50 to 1.00 [below minimum acceptable]).

8. Is the ratio of total assets to total liabilities, reflected in **either the audited balance sheet for the last completed fiscal year or the Entity-Wide Pro Forma Balance Sheet for the most recent month end,** less than 1.00 to 1.00 (minimum acceptable overall ratio)? ☐ Yes ☐ No

(Example: total assets = $8,000; total liabilities = $10,000; total ratio = .80 to 1.00 [below minimum acceptable]).

If the answer to either question 7 or 8 is Yes, you **must** submit a financial recovery plan, specifying your organization's planned actions/activities and related timeframe, to upgrade the current ratio and/or total ratio to at least the minimum acceptable levels in the current and, if necessary, succeeding fiscal year. In addition, the financial recovery plan should address any other condition(s) known to management that may have a negative impact on the organization's financial viability.

{ATTACH A COPY OF THE FINANCIAL RECOVERY PLAN AND INITIAL HERE} **]**

CERTIFICATION STATEMENT

I certify that the questions and Entity-Wide Pro Forma Balance Sheet, comprising this Form, as well as the attached Financial Statements (if submitted in response to question No. 5) and Financial Recovery Plan (if required), have been completed fully and correctly, to the best of my knowledge and belief.

Chief Financial Officer Name/Title (Print)		
Signature	Date	Telephone Number
Chief Executive Officer Name/Title (Print)		
Signature	Date	Telephone Number

Service Provider Legal Name	Information Submitted as of:
ASSETS	
Cash in Bank	**$**
Grants/Funds Receivable **(Attach Account Detail)**	
Other Accounts Receivable **(Attach Account Detail)**	
Other Current Assets **(Attach Account Detail)**	$
Total Current Assets	
Security Deposits	
Fixed Assets **(Net of Depreciation)**	
Other Non-Current Assets **(Attach Account Detail)**	
Total Assets	**$**

LIABILITIES AND NET ASSETS/EQUITY	
Payroll Taxes Payable - Federal	**$**
Payroll Taxes Payable - NYS & local	
Accounts Payable & Accrued Expenses **(Attach Account Detail)**	
Other Current Liabilities (i.e., Notes Payable, Current Portion of Long Term Debts, etc.) **(Attach Account Detail)**	
Total Current Liabilities	$
Long-Term Notes Payable **(Attach Account Detail)**	
Mortgage Payable	
Other Long-Term Liabilities **(Attach Account Detail)**	
Total Liabilities	$
Net Assets/Equity	
Total Liabilities and Fund Balance/Equity	**$**

Note: **(1) Current, as used above in conjunction with assets and liabilities, means resources available for use (assets) or amounts coming due (liabilities) within the next 12 month period.**

(2) If the accrual basis of accounting is not used, accurate receivable and payable account balances should be reported based on management's best knowledge and belief.