NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Problem Gambling Services Application

Entity/Administrative Headquarters Mailing Address			
Applicant's Legal Name			
Street	Room/Suite	Floor	PO Box or Postal Route
City, Town, Village		State **NY**	Zip Code + 4

Application Contact Person	
Name of Contact Person	Position/Affiliation with Applicant
Address (Street, City, State, Zip Code)	
Telephone Number	E-Mail Address

Certifications and Assurances

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 this form 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 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 must include a signed and dated statement authorizing the proposed action.

2. Certification of Finders Fees and Other Considerations

I certify, under penalty of perjury, that no fees or other considerations will be paid or tendered to any individual, group, agency or organization for referrals to the services to be provided by this applicant, including payment of the expenses of the referral source incidental to the making of a referral.

Signature of Authorized Representative _____ Position/Affiliation with Applicant _____ Date _____

3. Assumption of Financial Risk – **Non-OASAS Funded Applicants Only**

The applicant certifies and assures that it is prepared to assume (or will continue to assume) any and all financial risk in the development and operation of the services proposed and that sufficient financial resources are available for the startup and continuing operation of such services. The applicant further certifies, under penalty of perjury, and assures that it will not seek OASAS funding for the specific services under the circumstances described in this application.

Signature of Governing Authority Principal _____ Position/Affiliation with Applicant _____ Date _____

4. Certifications by a Principal of the Governing Authority

I certify that I am aware of and will comply with the requirements for operation in accordance with an operating certificate and the obligation to be certified prior to initiating operation of the services proposed in this application. **I understand that the program will be assigned an account in the NYCPG Portal which is used to make referrals for problem gambling treatment services and that information in this account must be kept up to date and the account will be activated on an annual basis provided the program remains in good standing. I attest that my agency is aware of and will comply with the requirements in the Ambulatory Patient Groups (APG) Clinical and Medicaid Billing Guidance regarding billing for the problem gambling services.** https://www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf I futher certify, under penalty of perjury, that all the information contained in this application is accurate, true and complete in all material aspects.

Signature of Governing Authority Principal _____ Position/Affiliation with Applicant _____ Date _____

Applicant's Legal Name			
Identification of Site where Problem Gambling Services are to be added			
Street		Room/Suite	Floor
City, Town, Village	State NY	Zip Code + 4	Last 5 digits of Current OC#

Written Plan

ATTACHMENT #3 refer to 857.5(b)(2) Include a written plan addressing the following:

- Admission criteria and screening tools;
- confidentiality;
- staffing, supervision and staff training;
- reporting and recordkeeping;
- programming specific to gambling-only treatment services, such as financial counseling and planning, individual, group and family counseling;
- policies and procedures addressing potential conflicts of interest involving staff with outside employment.

Operational Policies and Procedures

Include as **ATTACHMENT #4**

In addition to the policies and procedures required by a program's other certified service(s), programs offering gambling treatment (as secondary to SUD or as gambling-only) must develop policies and procedures specific to the level of gambling treatment provided including, but not limited to:

- Standards of conduct for staff related to providing clinical treatment, self-help support or any other professional service in another independent program, community and/or private practice setting;
- Provisions to admit without a full diagnosis for a gambling disorder;
- Services must include financial counseling and planning (on site or by referral).
- Gambling Free Policies – refer to LSB-2019-01

Staffing – List gambling staff below - Include as **Attachment #5 -** Copy of Credential for each staff providing Gambling Services **(attach additional sheets as necessary)**

Name/Title		Qualified Problem Gambling Professional	Schedule (i.e., M – F 9am-5pm)
	Gambling Clinical Supervisor		

Prepare a Budget for the proposed new service

A.	Budget Item Description	Proposed Operating Budget	
		Pre-Operational	Annual
Revenues	Client/Patient Fees		
	Temporary Assistance to Needy Families – TANF (formerly AFDC)		
	Safety Net Assistance – SNA (formerly Home Relief)		
	Medicaid (Managed Care)		
	Medicaid (Fee for Service)		
	Medicare		
	Private Health Insurance (Managed Care)		
	Private Health Insurance (Fee for Service)		
	Congregate Care Benefit Payments		
	Federal Grants (Other than through OASAS)		
	State Grants (Other than OASAS)		
	Local Government Grants		
	Cash Donations from Closely Allied Entities		
	Sale of Goods and Services (Sales Contracts/Purchase of Services Agreements)		
	Other Cash Resources (List Source and Amounts)		
	Total Revenues		

Applicant's Legal Name			
B. Expenses	**Budget Item Description**	**Proposed Operating Budget**	
		Pre-Operational	**Annual**
	Personal Services (Salaries/Wages)		
	Personal Services (Fringe Benefits)		
	Consultants/Professional Services		
	Equipment to be Expensed		
	Property Expense		
	Other Non-Personal Services Expenses		
	Allocated Provider Administration (Management & General/Overhead)		
	Total Expenses		
C. Profit/(Deficit)	**Total Revenues Less Total Expenses**		
D. Sources of Deficit Financing, If Any	OASAS State Aid		
	Other Deficit Funding Sources (List Sources and Amounts)		

Local Governmental Unit Approval	
I have reviewed this request to add Problem Gambling Services and recommend	
☐ **Approved**	☐ **Disapproval**
Comments:	
Signature	Name (Print)
Title (Print)	Date

OASAS Regional Office Approval		
I have reviewed this request to add Problem Gambling Services and recommend		
☐ **Approved**	☐ **Disapproval**	
Comments:		
Program Manager Signature	Name (Print)	Date
Regional Office Coordinator Signature	Name (Print)	Date
District Director Signature	Name (Print)	Date