NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

APPLICATION SUMMARY

Applicant's Consultation

The Certification Proposal – Prior Consult form (**ATTACHMENT #1A**) **must** be completed and included with the certification application submission as proof of prior consultation with the Local Governmental Unit and Field Office.

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

Summary of Application

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

☐ New OASAS Provider	☐ New Sponsor	☐ New Treatment Service	☐ Capacity Increase
☐ Minor Relocation	☐ Relocation	☐ Space Expansion	☐ Additional Location
☐ Merger	☐ Transfer of Ownership	☐ Capital Project	☐ Change in Ownership Status

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 start up 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 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

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

APPLICATION SUMMARY

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

Local Support

Include as **Attachment #2A**, a summary and proof of your outreach 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 officials.

Proximity (miles) to Nearest Community Facility (e.g., School, Religious Center, Child Care Facility)	Type of Facility

Identification of Sites and Services Affected by this Application

☐ None ☐ As Detailed Below

Site #1

Site Address ☐ Not Yet Selected **(New Providers Only)**

Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
			Current	Proposed	Current	Proposed	
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						

Site #2

Site Address ☐ Not Yet Selected **(New Providers Only)**

Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
			Current	Proposed	Current	Proposed	
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						

Site #3

Site Address ☐ Not Yet Selected **(New Providers Only)**

Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
			Current	Proposed	Current	Proposed	
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						
	☐ New ☐ Existing						

*Last 5 digits only

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART II – SITE INFORMATION

Applicant's Legal Name

A. Address of Existing/Proposed Site (For Additional Location see Section C)

Building/Building No. ☐ Not Yet Selected **(New Providers Only)**			Room/Suite	Floor	PO Box/Postal Route
Street	City, Town, Village	State **NY**	Zip Code + 4	County	
NYS Assembly District	NYS Senate District	Congressional District	NYC Community Bd. ☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens ☐ Staten Island		Board No.

B. Action Proposed

☐ Expand an Existing Site (Proceed to Section D) ☐ Establish a New Site (Proceed to Section D) ☐ Relocate to Another Site (Proceed to Section D) ☐ Establish an Additional Location Associated with the above Site (Proceed to Section C)

C. Address of Additional Location

Building/Building No. ☐ Not Yet Selected			Room/Suite	Floor	PO Box/Postal Route
Street	City, Town, Village	State **NY**	Zip Code + 4	County	
NYS Assembly District	NYS Senate District	Congressional District	NYC Community Bd. ☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens ☐ Staten Island		Board No.

D. Property Acquisition

Acquisition Status for this Site or Additional Location, as appropriate

☐ Currently Owned by Applicant (Proceed to Section G) ☐ Currently Leased by Applicant ☐ Proposed Purchase ☐ Proposed Lease

*Include as **ATTACHMENT #8** a copy of the purchase offer agreement/contract or existing/proposed lease or sublease.* ***Please note that any existing or proposed lease must contain the landlord's right to re-entry clause – refer to the instructions for required right-to-entry clause.***

E. Source of Funds for Purchase or Lease

Source	OASAS			
Dollar Amount	$	$	$	$

F. Real Property Interest of Applicant

Indicate if any of the following have a real property interest in the land, building or equipment at this site/additional location:

☐ 1. Governing authority member, officer, stockholder or employee or
☐ 2. Any relative of a governing authority member, officer, stockholder or employee or
☐ 3. Any other entity of which a governing authority member, officer, stockholder or employee is a member.
☐ 4. Not applicable

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

G. Capital Investment Needs of Property

Indicate if the property acquired (will require) rehabilitation or construction work. ☐ Yes ☐ No

1. If "No", proceed to Section I
2. If "Yes",
   a. Describe in **ATTACHMENT #10**, the work that was (needs to be) done to bring the property into compliance with OASAS facility standards, other OASAS regulations and all local codes and laws. The description should address all appropriate issues identified in the instructions.
   b. Indicate how this capital investment was (will be) financed:
      ☐ Capital Financing by the Applicant (Proceed to Item 2 c & d below) ☐ Cost (to be) Financed by Landlord and Recovered in the Lease (Proceed to Section I)
   c. Indicate if the work required (will require) a new, amended or temporary Certificate of Occupancy: ☐ Yes ☐ No
   d. Indicate if the applicant-financed construction/rehabilitation work has been completed. ☐ Yes ☐ No
      (1) If "No", the applicant has a choice of completing Section H now or later when the capital project is nearing completion.
      ☐ Complete Section H now ☐ Complete Section H later
      (2) If "Yes", complete Section H.

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART II – SITE INFORMATION (CONTINUED)

Applicant's Legal Name

H. Capital Financing Requirements for Site or Additional Location (as appropriate)

1. Name of Project Architect/Engineer | Telephone Number

Business Address (Street, City State, Zip Code)

2. Capital Project Costs (See Instructions)

Cost Item	Amount
a. Site Acquisition	$
b. Construction/Renovation	
c. Design	
d. Equipment	
e. Other (specify)	
Total Estimated Cost	$

3. Sources of Capital Project Financial Support

Source	Amount
a. OASAS	$
b.	
c.	
d.	
e.	
Total Estimated Financing	$

4. Proposed Construction Start Date

I. Site Drawings and Photographs

Check the items that apply and, as appropriate, submit required documents.

☐ a. This site or additional location has not yet received OASAS approval for chemical dependence treatment services by the applicant.

☐ b. Structural and/or floor plan changes are being made by the applicant to this previously OASAS-approved site or additional location.

☐ c. This application does not involve structural or floor plan changes that require OASAS approval.

*If Item a or b is selected, include as **ATTACHMENT #11**: general site drawings, floor plan sketches to scale, and photographs of all sides of the outside structure, per instructions.* ***Please note that floor plans must be of good quality and legible. Refer to Part 814 – General Facility Requirements or Part II, Section I, of the instructions for specific elements that must be included on floor plans.***

J. Setting for Site or Additional Location

Select the setting, as described in the instructions, in which the site or additional location is (will be) situated.

☐ Community
☐ Hospital – On Premises
☐ Hospital – Off Premises
☐ Shelter Plus Care Housing
☐ Other Health Facility
☐ Mental Health Facility
☐ FQHC
☐ Other (specify) _____
☐ OCFS Facility
☐ School
☐ Shelter

K. OASAS Physical Plant Inspections

Check yes or no if OASAS has conducted a physical plant inspection for this site/additional location. ☐ Yes ☐ No

If "Yes", indicate the date of the most recent inspection and proceed to Part III. If no, proceed to Section L.

L. Shared Space Issues

Indicate if the chemical dependence services at this site will share space with other providers of human services. ☐ Yes ☐ No
If **"Yes"**, describe below plans to set aside discrete space for chemical dependence services as well as plans for utilizing shared space.

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART II – SITE INFORMATION (Continued)

Applicant's Legal Name

M. Property Characteristics

1. Structure
☐ Wood Frame ☐ Block ☐ Concrete ☐ Steel ☐ Brownstone
☐ Other (Specify) _____

2. Exterior Walls
☐ Aluminum ☐ Clapboard ☐ Masonry
☐ Other (Specify) _____

3. Foundation
☐ Poured Concrete ☐ Concrete Block ☐ Other (Specify) _____

4. Building
☐ Fully Attached ☐ Semi Attached ☐ Freestanding
Building Size Sq. Ft.
# of Floors (exclude Basement)

5. Basement ☐ Yes ☐ No
If "Yes", will it be used for patient services? ☐ Yes ☐ No
Size of Basement Sq. Ft.

6. Area(s) to be used for Service(s)

Area	Floor # / Square Feet	Floor # / Square Feet	Floor # / Square Feet	Floor # / Square Feet	Floor # / Square Feet	Floor # / Square Feet
Area	Square Feet	Square Feet	Square Feet	Square Feet	Square Feet	Square Feet
No. of Exits						

7. Services/Utilities

a. Water Supply	b. Sanitary System	c. Power
☐ Well ☐ Municipal System ☐ Other _____	☐ Septic ☐ Municipal Sewer System ☐ Other _____	☐ Gas ☐ Oil ☐ Electric ☐ Other _____

N. Local Planning Requirements

1. Zoning Classification	2. Proposed use Conforms with Classification ☐ Yes ☐ No	3. Building Classification

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.

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART II – SITE INFORMATION (Continued)

Applicant's Legal Name

P. Accessibility to Disabled

Is this facility considered accessible for individuals with physical disabilities (e.g., access ramps, doorways, sanitary facilities)? If "No", describe arrangements, planned or in place, to provide for the disabled. ☐ Yes ☐ No

Q. Historical/ Environmental Significance of this Site or Additional Location (as appropriate)

1. Is this Site/Additional Location wholly or partially within or adjacent to any facility or site listed on the State or National Register of Historic Places? ☐ Yes ☐ No
2. Is the Site/Additional Location substantially contiguous to a site listed in the Register of Natural Landmarks? ☐ Yes ☐ No
3. Is the Site/Additional Location in a state Coastal Zone Management Area (CZM)? ☐ Yes ☐ No
4. Is the Site/Additional Location in a State or Local Critical Environment Area (CEA)? ☐ Yes ☐ No
5. The proposed Site/Additional Location will require:

   ☐ a planning or zoning change ☐ a zoning variance ☐ a special use permit
   ☐ a site plan approval ☐ none of the preceding
6. Does the Site/Additional Location have an adequate and safe water supply and wastewater disposal system? ☐ Yes ☐ No
7. Does the Site/Additional Location involve ten or more acres of property? ☐ Yes ☐ No
8. Discuss below any other environmental issues which may be reasonably anticipated at this Site/Additional Location.

R. Relocation Only

Does the proposed relocation affect the current operating budget or capacity? ☐ Yes ☐ No

If yes, include Part IV Resource Allocation with your application submission.

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES

Applicant's Legal Name	
Site/Additional Location Address ☐ Not Yet Selected **(New Providers Only)**	Service Type

Note: Part III is completed by applicants who are new to OASAS and wish to operate one or more new services, or by existing OASAS providers who are seeking approval to provide new services or to establish a service at an additional location. Section H is omitted for services at additional locations.

A. **Action Proposed**	Indicate the type of site action applicant is requesting. a. ☐ Provide a new service at this site b. ☐ Establish a service at an additional location at a **stand-alone location** (Outpatient Services Only) c. ☐ Establish a service at an additional location at **host agency** (Outpatient Services Only) *If "at host agency", provide as **ATTACHMENT #13** a description of the arrangements and reasons for establishing the additional location at the host agency.*
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 described in the application. In addition to the assessment, use existing OASAS need methodology where available. Include as **ATTACHMENT #14** information relative to need as specified in the instructions.
D. **Description of Services**	1. Describe the applicant's approach/philosophy regarding the treatment of chemical dependence; include use of self-help services, medication, individual/group counseling and other treatment techniques.
	2. List and define the specific service components to be offered to patients, including any proposed time-structured treatment regimen or module. Include as **ATTACHMENT # 15** the description of service components requested per instructions.
	3. For each planned service, provide a detailed list including, but not limited to: expected outcomes for patients, planned numbers and frequency of service delivery, planned length of stay and other proposed measures of success. Include as **ATTACHMENT # 16** the description of goals and objectives, per instructions.

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES (CONTINUED)

Applicant's Legal Name

Site/Additional Location Address ☐ Not Yet Selected **(New Providers Only)** | Service Type

E. Special Populations

Indicate below any special populations that these services are specifically designed to treat (see instructions for definitions).

☐ No Special Population(s) ☐ Youth ☐ Homeless ☐ COSA/COA
☐ Women ☐ Elderly ☐ Parole and/or Probation ☐ LGBT
☐ Pregnant Women ☐ HIV/AIDS ☐ Alternative to Incarceration ☐ Intravenous Drug Users
☐ Women w/Children ☐ MICA ☐ CASAT ☐ Other (Specify) _____

Describe specific programmatic efforts to be undertaken to ensure that services are provided to special populations, if any are designated above.

F. Proposed Operating Schedule (Specify a.m. or p.m.)

☐ 24 hours per day, 7 days per week

	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	From	To	From	To	From	To	From	To	From	To	From	To	From	To
Total Hours														
Medication Hours*														

***Opioid Treatment Services Only**

G. Projected Workload

Indicate the projected annual volume of services that will be provided at the main location and the additional location, if applicable.

☐ Not Applicable _____ Annual Visits (Main Location) _____ Annual Visits (Additional Location)

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, **including but not limited to**:

(Omit for services at additional locations)

- policies and procedures governing the criteria for the admission, continued stay and discharge of patients, including the ongoing evaluation process for identifying patients in need of a higher or lower level of care;
- policies and procedures for the preparation of individualized treatment plans, as appropriate, and for the preparation and maintenance of clinical records;
- policies and procedures for medical services and administration of medications;
- policies and procedures for conducting medical & laboratory tests, including staff involved & timeframes for testing;
- policies and procedures for identifying other medical and psychiatric conditions that require referral for acute medical and mental hygiene services;
- policies and procedures for the supervision of clinical care staff;
- policies and procedures for addressing quality improvement and utilization review;
- for applications involving **medically managed detoxification, medically supervised withdrawal** and **medically monitored withdrawal services**, policies, procedures and protocol governing withdrawal with medication, covering those issues specified in the instructions;
- policies and procedures governing a patient's rights to confidentiality;
- policies and procedures concerning HIV and AIDS;
- a patient's handbook of rights and responsibilities regarding participation in the services offered;
- procedures to provide patients with continuity of care consistent with treatment and discharge plans;
- policies and procedures governing billing and collection of patient fees;
- policies, procedures and methods governing patient rights;
- policies, procedures and methods governing the provision of a tobacco-free environment;
- policies, procedures and methods governing incident reporting; and
- any other policies and procedures required by OASAS regulations.

NOTE: For new opioid services, complete remaining Sections I-O of Part III; for other new services, proceed to Part IV.

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES (CONTINUED)

Applicant's Legal Name		
Site/Additional Location Address ☐ Not Yet Selected **(New Providers Only)**		Service **Opioid Treatment**

I. Key Opioid Program Staff	Chief Executive Officer	Medical Director
	Site Medical Director	Other (Specify)

J. Program Approval Status

	Application	Submitted	Approved	Other
Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (CSAT)	☐	☐	☐	☐
Drug Enforcement Administration	☐	☐	☐	☐
NYS Department of Health (Only required for Article 28 providers)	☐	☐	☐	☐

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

K. Alternative Emergency Medication Procedures

1. Describe arrangements for the medication of patients during emergency or holiday situations when the clinic is unable to open.

2. Indicate if the above arrangements are consistent with CSAT Guidelines. ☐ Yes ☐ No

L. Methadone Security

1. Storage Arrangements

☐ On-Site (Complete #2 below) ☐ Off-Site Location (Complete #3 below)

2. Describe the alarm system and other security measures for on-site methadone storage.

3. Describe security measures for the transport of methadone to and from the central pharmacy location.

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES (CONTINUED)

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

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

PART IV – RESOURCE ALLOCATION

Applicant's Legal Name			
Site Address		Service Type	
Prepare Part IV for each proposed new service at each site			
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		
B.	Personal Services (Salaries/Wages)		
	Personal Services (Fringe Benefits)		
	Consultants/Professional Services		
	Equipment to be Expensed		
	Property Expense		
Expenses	Other Non-Personal Services Expenses		
	Allocated Provider Administration (Management & General/Overhead)		
	Total Expenses		
C. Profit/(Deficit)	**Total Revenues less Total Expenses**		
D.	OASAS State Aid		
Sources of Deficit Financing, If Any	Other Deficit Funding Sources (List Sources and Amounts)		
E. Budget Assumptions	*Include as **Attachment #21** the assumptions used in developing the operating budget for the services indicated above. Also include with the attachment any existing/planned Rate Schedules and Sliding Fee Schedules used in developing revenue estimates.*		
F. **Financial Condition of Applicant**	Availability of Most Recent Financial Report (Note: Completion of this item is not required for new entities, all governmental entities and acute care general hospitals subject to Article 28 of the Public Health Law.) ☐ Independently Audited Annual Financial Statement - Latest Year Available _____ ☐ IRS Form 990 (Not-for-Profit Entities Only) – Latest Year Available _____ ☐ Entity Annual Financial Statements (Unaudited Balance Sheet and Income Statement) – Latest Year Available _____ *Include as **Attachment #22** a copy of the most recent annual financial statement/report per instructions. If none of the above statements/reports are available, include most recent tax return and/or a pro-forma balance sheet, per instructions (see Exhibit D).*		

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

PART IV – RESOURCE ALLOCATION

Applicant's Legal Name	
Site/Additional Location Address ☐ Not Yet Selected **(New Providers Only)**	Service Type

G. Staffing

Before completing this section, refer to the appropriate OASAS Operating Regulations to ensure the staffing pattern completed below meets regulatory compliance. List below, by job title, all staff positions (to be) assigned to the proposed new or expanded service. Under **"# of FTEs"** enter the total number of full-time equivalent staff in each job title. Under **"# of QHPs"** enter the number of staff to be employed in a particular job title who are Qualified Health Professionals. As appropriate for the type of services, enter the number of staff to be deployed on each shift and on weekends. For **additional locations**, also complete **Appendix II – Staff Deployment Matrix** for each affected site and service that provides outpatient services.

	Actual Job Title *Include as **Attachment #23** job descriptions for each job title listed.*	**# of FTEs**	**Total # of Staff**	**Identify by # QHPs**		**Planned Staff Deployment** (# to be assigned to each shift)			
				CASAC	**Other QHP**	Days	Evenings	Nights	Weekends
Management	Director of Services								
	Medical Director (if any)								
	Other (Identify)								
Direct Care Staff*	Medical Services								
	Nursing Services								
	Counseling Services								
	Rehabilitation Services								
	Other								
NON-Direct Support Staff									

*Typical professions employed in each of the services include but are not limited to: **Medical Services** – Physician, Psychiatrist, Nurse Practitioner, Physician's Assistant; **Nursing Services** – RN, LPN; **Counseling Services** – CASAC, CASAC-T, Family Therapist, Psychologist, Social Worker, Counselor; **Rehabilitation Services** – Occupational Therapist, Rehabilitation Counselor, Therapeutic Recreation Therapist, Vocational Counselor; **Other** – Acupuncturist.

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

For each job title listed on Page 2, identify the proposed work hours as prescribed in regulatory standards (specify a.m. or p.m.) Use one line per employee and one page per affected site.

H.	Proposed Work Schedule													
	Is the proposed service open 24 hours per day, 7 days per week? ☐ Yes ☐ No													
Job Title	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
	From	To	From	To	From	To	From	To	From	To	From	To	From	To

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.		

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

APPENDIX II – STAFF DEPLOYMENT MATRIX – OUTPATIENT TREATMENT SERVICES WITH ADDITIONAL LOCATIONS

Applicant's Legal Name	
Site Address	**Service Type**

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

		Actual Job Title	Total FTEs	Main Site	Additional Location #	Additional Location #	Additional Location #	Additional Location #
Management		Director of Services						
		Medical Director (if any)						
		Other (Identify)						
DIRECT CARE STAFF	Clinical Services							
	Nursing Services							
	Counseling Services							
	Rehabilitation Services							
	Other							
NON-Direct / Support Staff								

Address of Additional Location #

Address of Additional Location #

Address of Additional Location #

Address of Additional Location #