

**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.			
<input type="checkbox"/> New OASAS Provider	<input type="checkbox"/> New Sponsor	<input type="checkbox"/> New Treatment Service	<input type="checkbox"/> Capacity Increase
<input type="checkbox"/> Minor Relocation	<input type="checkbox"/> Relocation	<input type="checkbox"/> Space Expansion	<input type="checkbox"/> Additional Location
<input type="checkbox"/> Merger	<input type="checkbox"/> Transfer of Ownership	<input type="checkbox"/> Capital Project	<input type="checkbox"/> 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 further 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	

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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								
<input type="checkbox"/> None <input type="checkbox"/> As Detailed Below								
Site #1	Site Address <input type="checkbox"/> Not Yet Selected (New Providers Only)							
	Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
		<input type="checkbox"/> New <input type="checkbox"/> Existing		Current	Proposed	Current	Proposed	
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
Site #2	Site Address <input type="checkbox"/> Not Yet Selected (New Providers Only)							
	Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
		<input type="checkbox"/> New <input type="checkbox"/> Existing		Current	Proposed	Current	Proposed	
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
Site #3	Site Address <input type="checkbox"/> Not Yet Selected (New Providers Only)							
	Services	Status	Persons Served Annually	Capacity		Units of Service		OASAS Cert. No.*
		<input type="checkbox"/> New <input type="checkbox"/> Existing		Current	Proposed	Current	Proposed	
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						
		<input type="checkbox"/> New <input type="checkbox"/> Existing						

*Last 5 digits only

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(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES

Applicant's Legal Name	
Site/Additional Location Address <input type="checkbox"/> 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.	<p>Indicate the type of site action applicant is requesting.</p> <p>a. <input type="checkbox"/> Provide a new service at this site</p> <p>b. <input type="checkbox"/> Establish a service at an additional location at a stand-alone location (Outpatient Services Only)</p> <p>c. <input type="checkbox"/> Establish a service at an additional location at host agency (Outpatient Services Only)</p> <p><i>If "at host agency", provide as ATTACHMENT #13 a description of the arrangements and reasons for establishing the additional location at the host agency.</i></p>
B.	<p>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.</p>
C.	<p>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.</p> <p style="text-align: center;">Include as ATTACHMENT #14 information relative to need as specified in the instructions.</p>
D.	<p>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.</p> <p>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.</p> <p>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.</p>

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(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES (CONTINUED)

Applicant's Legal Name															
Site/Additional Location Address <input type="checkbox"/> 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). <input type="checkbox"/> No Special Population(s) <input type="checkbox"/> Youth <input type="checkbox"/> Homeless <input type="checkbox"/> COSA/COA <input type="checkbox"/> Women <input type="checkbox"/> Elderly <input type="checkbox"/> Parole and/or Probation <input type="checkbox"/> LGBT <input type="checkbox"/> Pregnant Women <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Alternative to Incarceration <input type="checkbox"/> Intravenous Drug Users <input type="checkbox"/> Women w/Children <input type="checkbox"/> MICA <input type="checkbox"/> CASAT <input type="checkbox"/> Other (Specify) _____														
	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.)	<input type="checkbox"/> 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. <input type="checkbox"/> 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.															

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(Read Instructions Carefully Before Completion)

PART III – DESCRIPTION OF SERVICES (CONTINUED)

Applicant's Legal Name					
Site/Additional Location Address <input type="checkbox"/> Not Yet Selected (New Providers Only)				Service Opioid Treatment	
M. Staffing	Staff Position	Name	License No.	# Days on Site	Daily Hours on Site
	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. <i>Include as ATTACHMENT #20 a description of treatment services.</i>				

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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		
	Expenses	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			
Sources of Deficit Financing, If Any	OASAS State Aid			
	Other Deficit Funding Sources (List Sources and Amounts)			
E. Budget Assumptions	<i>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.</i>			
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.)			
	<input type="checkbox"/> Independently Audited Annual Financial Statement - Latest Year Available _____			
	<input type="checkbox"/> IRS Form 990 (Not-for-Profit Entities Only) – Latest Year Available _____			
	<input type="checkbox"/> Entity Annual Financial Statements (Unaudited Balance Sheet and Income Statement) – Latest Year Available _____			
	<i>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).</i>			

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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 <i>Include as Attachment #23 job descriptions for each job title listed.</i>		# 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.

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PART V - SERVICE CAPACITY INCREASES IF APPLICABLE OR TRANSFER OF OWNERSHIP

Applicant's Legal Name						
Site Address		Service Type				
Note: Part V is completed by applicants who are existing OASAS providers that wish to: (1) increase the certified capacity of existing chemical dependence treatment services or (2) acquire ownership of certified services from another OASAS provider.						
A. Action Requested	Check all that apply <input type="checkbox"/> Increase in Capacity (Go to B. below) <input type="checkbox"/> Transfer the above service from _____ (Go to C. below) Name of OASAS Provider					
B. Service Capacity Increase	1. Capacity Data <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-right: 1px solid black; padding: 5px;">a. Current Approved Service Capacity</td> <td style="width: 33%; border-right: 1px solid black; padding: 5px;">b. Requested Service Capacity</td> <td style="width: 33%; padding: 5px;">c. Increase</td> </tr> </table>			a. Current Approved Service Capacity	b. Requested Service Capacity	c. Increase
a. Current Approved Service Capacity	b. Requested Service Capacity	c. Increase				
C. Impact of Action	1. Space <input type="checkbox"/> None <input type="checkbox"/> Additional/Re-arrangement of space described in Part II – Site Information					
	2. Units of Service <input type="checkbox"/> None <input type="checkbox"/> Increase by _____ Patient Days/Visits					
	3. Staffing <input type="checkbox"/> None <input type="checkbox"/> Increase* by _____ FTEs					
	*List FTE staffing changes below:					
		Job Title	Existing FTEs	Revised FTEs		
				Net Change		
D. Financial Commitments	Financial Commitments to Support Actions Requiring Additional Staff/Space (Check all that apply) <input type="checkbox"/> No Additional Financing Needed <input type="checkbox"/> OASAS Financing Committed <input type="checkbox"/> Other Funding Sources Committed - Source(s) _____ _____					
E. Issues Affecting This Action	Issues to Address Regarding This Action Covering the Topics Identified in the Instructions <p style="text-align: center;"><i>Include as ATTACHMENT #24 a narrative description which covers issues outlined in the instructions.</i></p>					