NEW YORK STATE
OFFICE OF ADDICTIONS SERVICES AND SUPPORTS

Certification Proposal – Prior Consult

Attachment 1A

This form must include Local Government Unit (LGU) and Regional Office (RO) signatures. Include this form with submission of the Certification Application (PPD-5) as proof of prior consultation with the LGU and RO. Please note that this document is not an application.

Section 1	**Entity/Administrative Information**		
Applicant's Legal Name (Existing Entities Only)		Proposed Name (If proposal involves a new entity or a name change)	
Building/Building #	Room/Suite	Floor	PO Box or Postal Route
Street Address			
City	Town	Village	
State	Zip Code + 4	Telephone Number (including Area Code)	
E-Mail Address		Fax Number (including Area Code)	

Section 2 Proposal Information

Check the box(es) that identifies the proposed action(s).

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

Service Identification

Identify the new service(s) to be provided. Regulatory requirements for chemical dependence services can be found on the OASAS website at the following link: http://www.oasas.ny.gov/regs/index.cfm.

Briefly describe the action/service proposed.

Please describe 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 official(s).

Site and Staffing – Describe the location, including the address (if known) of each of the services proposed, the geographic or political boundaries of the area to be served, the need for the proposed service(s) in the service area, and the proposed staffing pattern for each service proposed.

Description of Services - Describe the approach/philosophy regarding the treatment of chemical dependence, including use of self-help services, medication, individual/group counseling, and other treatment techniques. **(To be completed only by entities that are not currently authorized to provide OASAS treatment services.)**

Section 3 Entity Status

Current Type of Entity	Proposed (If proposal includes a change in type of entity)
☐ Individual Proprietorship	☐ Individual Proprietorship
☐ Partnership	☐ Partnership
☐ Limited Liability Partnership	☐ Limited Liability Partnership
☐ Not-for-Profit Corporation	☐ Not-for-Profit Corporation
☐ Business Corporation	☐ Business Corporation
☐ Limited Liability Company	☐ Limited Liability Company
☐ State Agency	☐ State Agency
☐ County Department/Agency	☐ County Department/Agency
☐ Municipal Department/Agency	☐ Municipal Department/Agency
☐ Public Benefit Corporation	☐ Public Benefit Corporation
☐ Other (Specify)	☐ Other (Specify)

Current Entity Relationship to OASAS

☐ New Entity (see below) ☐ Existing Non-OASAS Entity (see below) ☐ OASAS Entity OASAS Provider No.

To Be Completed by New Entities and by Existing Non-OASAS Entities Only

Entity Licenses, Certifications and Accreditations – Check each license, certification and/or accreditation held (include out-of-state licenses, etc. in "Other"

☐ NYS Office of Mental Health ☐ NYS Office for People with Developmental Disabilities

☐ NYS Department of Health ☐ NYS Office of Family and Children's Services

☐ NYS Department of Education ☐ The Joint Commission

☐ Other (specify)

Entity Experience in Chemical Dependence Services

If the applicant has not been previously certified by OASAS, include as an **Attachment** a brief history of the entity's experience in providing chemical dependence services, including alcoholism and substance abuse services, along with other human services.

Section 4 Application Contact Person

Name of Contact Person	Position/Affiliation with Applicant
Address (Street, City, State, Zip Code + 4)	
Telephone Number	Fax Number / E-Mail Address

Section 5

Site Budget

Prepare this section for each proposed new service at each site.

	Budget Item Description	Proposed Operating Budget	
		Pre-Operational	Annual
A. 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. 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. Construction	Estimated Capital Cost		
	Acquisition		
	Construction		
	Renovation		
	Total Capital Expenses		
D. Profit/(Deficit)	**Total Expenses less Total Revenues**		
	OASAS State Aid		
E. Sources of Deficit Financing, If Any	Local Government (Tax Levy)		
	Other Deficit Funding Sources (List Sources and Amounts)		

Section 6	Signatures	
Applicant Representative (Print Name)	**Applicant Representative Signature**	**Date**
LGU Representative (Print Name)	**LGU Representative Signature**	**Date**

Recommendation for the provider to submit a Certification Application ☐

LGU Comments

RO Representative (Print Name)	**RO Representative Signature**	**Date**

Recommendation for the provider to submit a Certification Application ☐

RO Comments