Adolescent Program Designation Attestation

A program applying to be a Designated Adolescent Program must complete this attestation and submit it to NYS OASAS, Bureau of Certification by e-mail at Certification@oasas.ny.gov. Use additional pages if necessary.

Providers applying for the APD in more than one PRU may submit one attestation but must complete and submit a separate self-assessment for each PRU.

PROGRAM INFORMATION		
Applicant Program's Legal Name		Provider Number
Operating Certificate Number(s)		PRU
PRU Location (Street, City, State, Zip Code)		
Administrative Office Address (Street, City, State, Zip Code)		
Name of Contact Person		Position/Affiliation with Applicant
Telephone Number for Contact Person		E-mail Address of Contact Person
Do you want to include the additional locations that are on the operating certificate addendum? ☐ Yes ☐ No		
Number of Youth Served Per Year	Average Length of Stay (Ages 12-26)	Age Range of Youth Clients Served
Years of Agency Experience Serving Youth	Current EBP(s) Used for Youth Services	
Years of Agency Experience Serving Families	Current EBP(s) Used for Family Services	
Days/Hours of Operation for Youth Services		
Approximate Number of Individual Sessions with Adolescents per Week		Approximate Number of Adolescent Groups per Week

Number of Staff Dedicated to Youth Services	Licenses/Certifications of Adolescent-Serving Staff (e.g., LCSW, LMHC, CASAC, CRPA)
Partnerships with Outside Youth-Specific Entities (e.g., pediatricians, non-profits, other behavioral health service providers, recovery support programs, schools) (Applicant may attach a list of MOUs/linkages)	
What adolescent-specific screening instruments does your program use for domains including, but not limited to, substance use, general mental health, suicide risk, and trauma?	
How would the agency benefit from receiving the Adolescent Program Designation?	

ADOLESCENT PROGRAM DESIGNATION ATTESTATION	
1.	The services being offered by the above-noted program are in accordance with OASAS Part 830.
2.	Clinical staff are trained in topics related to adolescent substance use disorder, including (but not limited to) adolescent development, cultural humility, trauma-responsive care, case management, effective SUD treatment approaches for adolescents, and youth-specific screenings and assessments.
3.	Assessment instrument(s) for substance use and co-occurring mental health issues are standardized, developmentally appropriate, and evaluate key domains, including (but not limited to) demographics, substance use history, developmental functioning, family and other interpersonal relationships, trauma history, and resiliencies/strengths.
5.	Policies and procedures are in place for, at minimum: • Outreach, engagement, and retention strategies (see standard 3a) • Mental health treatment (see standard 6b) • Reporting for injuries and emergencies (see standard 7a) • Filing of client complaints (see standard 7b) • Emotional and physical safety of youth, including bullying (see standard 9a) • Availability and use of medication for addiction treatment /recovery for adolescents (see standard 12a) • HIPAA messaging compliance (see standard 3e) **Copies of the above-listed policies and procedures are included with the applicant's submission. Applicant is encouraged to attach additional youth-specific policies and procedures not listed above.**
6.	Applicant can provide medication for addiction treatment to adolescents on-site or by referral.
7.	**The applicant program understands that to be eligible to receive and retain an Adolescent Program Designation, the applicant must have an OASAS operating certificate in good standing.**

Part 830 permits qualifying programs (certified pursuant to Article 32 of the NYS Mental Hygiene Law and if approved to do so by OASAS) to be designated as an adolescent-serving program. Approval shall be based upon acceptance of this Attestation and the APD Self-Assessment (and accompanying documentation).

Statement of Compliance and Signature

I, ____, hereby attest that the Adolescent Program Designation standards identified on this attestation form are true, accurate, and complete to the best of my knowledge and that the program noted above is in compliance with Part 830 "Designated Services" regulation. I understand that any falsification, omission, or concealment of material fact may result in revocation of the Adolescent Designation at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability.

Provider Representative Signature:	Date:
OASAS Regional Office Program Manager Signature:	Date:
Regional Office Program Manager Comments (optional):	
LGU Signature:	Date:
LGU Comments (optional):	