

OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

(Read Instructions Carefully Before Completion)

APPLICATION SUMMARY

Applicant's Consultation			
With OASAS Field Office Name	Date	With Local Governmental Unit Name	Date
Applicant's Legal Name			
Entity Administrative Headquarters Mailing Address			
Building/Building #		Telephone No.	
Street	Room/Suite	Floor	PO Box or Postal Route
City, Town, Village		State	Zip Code Plus 4
Summary of Application			
Check the appropriate category and provide a brief summary of the purpose for submitting this application, as prescribed in Chapter I of the detailed instructions; i.e., the type(s) of actions(s) for which you are seeking OASAS approval, consistent with the requirements of 14 NYCRR Part 810. <i>(Use additional sheets as necessary.)</i>			
<input type="checkbox"/> New OASAS Provider	<input type="checkbox"/> Minor Relocation	<input type="checkbox"/> Transfer of Ownership	
<input type="checkbox"/> New Treatment Service	<input type="checkbox"/> Relocation/Space Expansion	<input type="checkbox"/> Capital Project	
<input type="checkbox"/> Capacity Increase	<input type="checkbox"/> Additional Location	<input type="checkbox"/> Change in Ownership Status	

Certifications and Assurances			
1. Authorization to Represent Applicant			
I certify, under penalty of perjury, that I have been authorized by a resolution of the governing authority of the applicant, identified above, to act on its behalf in the preparation and filing of this application.			
_____	_____	_____	_____
Signature of Authorized Representative	Position/Affiliation with Applicant	Date	
<i>Include as ATTACHMENT #1 a copy of the resolution authorizing such representation.</i>			
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 Official or 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 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	
APPLICATION AUTHORIZATION			
I am authorized by the governing authority of the above named applicant to submit this application.			
_____	_____	_____	_____
Signature	Printed/Typed Name	Date	
Affiliation with Applicant:	<input type="checkbox"/> Individual Proprietor	<input type="checkbox"/> General Partner	<input type="checkbox"/> Board Member
	<input type="checkbox"/> Employee	<input type="checkbox"/> Director of Community Services	<input type="checkbox"/> Stockholder
	<input type="checkbox"/> State Agency/Dept. Head	<input type="checkbox"/> Municipal Dept. Head	<input type="checkbox"/> Other (Specify): _____
Corporate Entities Only: Include as ATTACHMENT #2 a corporate resolution that authorizes submission of this application.			

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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 No.	FAX No.	E-Mail Address

Identification of Sites and Services Affected by this Application

None As Detailed Below:

Site #	Site Address	<input type="checkbox"/> Not Yet Selected		Status	Persons Served	Capacity*		Units of Service*		OASAS Cert. No.**
	Service(s)*		Current			Proposed	Current	Proposed		
Site #1	Site Address		<input type="checkbox"/> Not Yet Selected							
	Service(s)*									
			<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							
	Service(s)*									
			<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							
	Service(s)*									
			<input type="checkbox"/> New							
			<input type="checkbox"/> Existing							
			<input type="checkbox"/> New							
		<input type="checkbox"/> Existing								

*See Exhibit A for a list of services.

**Last 5 numbers only.

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PART II – SITE INFORMATION

APPLICANT'S LEGAL NAME										
A	NAME OF SITE, IF ANY	<input type="checkbox"/> No Name Attached to Site								
B	ADDRESS OF EXISTING/ PROPOSED SITE	Building/Building # <input type="checkbox"/> Not Yet Selected				Room/Suite	Floor	PO Box or Postal Route		
		Street			City, Town, Village			State	Zip Code Plus 4	County
		NYS Assembly District	NYS Senate District	Congressional District	NYC Community Bd. No. (Check Borough and enter number)			Board No.		
			<input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island							
C	ACTION PROPOSED	<input type="checkbox"/> Expand an Existing Site <i>(Proceed to Section E)</i>		<input type="checkbox"/> Establish a New Site <i>(Proceed to Section E)</i>		<input type="checkbox"/> Relocate to Another Site <i>(Proceed to Section E)</i>		<input type="checkbox"/> Establish an Additional Location Associated with the Above Site <i>(Proceed to Section D)</i>		
D	ADDRESS OF ADDITIONAL LOCATION	Building/Building # <input type="checkbox"/> Not Yet Selected				Room/Suite	Floor	PO Box or Postal Route		
		Street			City, Town, Village			State	Zip Code Plus 4	
		NYS Assembly District	NYS Senate District	Congressional District	NYC Community Bd. No. (Check Borough and enter number)			Board No.		
			<input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island							
E	PROPERTY ACQUISITION	Acquisition Status for this Site or Additional Location, as appropriate								
		<input type="checkbox"/> Currently Owned by Applicant <i>(Proceed to Section H)</i>		<input type="checkbox"/> Currently Leased by Applicant		<input type="checkbox"/> Proposed Purchase		<input type="checkbox"/> 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 in §810.7(d)								
F	SOURCE OF FUNDS FOR PURCHASE OR LEASE	Source:	OASAS							
		Dollar Amount	\$		\$		\$		\$	
G	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: <ul style="list-style-type: none"> <input type="checkbox"/> governing authority member, officer, stockholder or employee or <input type="checkbox"/> any relative of a governing authority member, officer, stockholder or employee or <input type="checkbox"/> any other entity of which a governing authority member, officer, stockholder or employee is a member. <input type="checkbox"/> not applicable If any item above 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.								
H	CAPITAL INVESTMENT NEEDS OF PROPERTY	Indicate if the property required (will require) rehabilitation or construction work. <input type="checkbox"/> Yes <input type="checkbox"/> No <ol style="list-style-type: none"> 1. If "No", proceed to Section J. 2. If "Yes", <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> <input type="checkbox"/> Capital Financing by the Applicant <i>(Proceed to item 2. c. & d. below)</i> <input type="checkbox"/> Cost (to be) Financed by Landlord and Recovered in the Lease <i>(Proceed to Section J)</i> c. Indicate if the work required (will require) a new, amended, or temporary Certificate of Occupancy: <input type="checkbox"/> Yes <input type="checkbox"/> No d. Indicate if the applicant-financed construction/rehabilitation work has been completed: <input type="checkbox"/> Yes <input type="checkbox"/> No (1) If "No", the applicant has a choice of completing Section I now or later when the capital project is nearing completion. <ul style="list-style-type: none"> <input type="checkbox"/> Complete Section I now <input type="checkbox"/> Complete Section I later (2) If "Yes", complete Section I								

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PART II – SITE INFORMATION (CONT'D)

APPLICANT'S LEGAL NAME																																	
N PROPERTY CHARACTERISTICS	1. Structure <input type="checkbox"/> Wood Frame <input type="checkbox"/> Block <input type="checkbox"/> Concrete <input type="checkbox"/> Steel <input type="checkbox"/> Brownstone <input type="checkbox"/> Other																																
	2. Exterior Walls <input type="checkbox"/> Aluminum <input type="checkbox"/> Clapboard <input type="checkbox"/> Masonry <input type="checkbox"/> Other																																
	3. Foundation <input type="checkbox"/> Poured Concrete <input type="checkbox"/> Concrete Block <input type="checkbox"/> Other																																
	4. Building <input type="checkbox"/> Fully Attached <input type="checkbox"/> Semi-Attached <input type="checkbox"/> Freestanding <table style="float: right; border: none; margin-left: 20px;"> <tr> <td style="border: none;">Building Size</td> <td style="border: none;">No. of Floors (Excluding Basement)</td> </tr> <tr> <td style="border: none;">Sq. Ft.</td> <td style="border: none;"></td> </tr> </table>	Building Size	No. of Floors (Excluding Basement)	Sq. Ft.																													
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	Sq. Ft.																																
	5. Basement Does building have a basement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", will it be used for client services? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="float: right; border: none; margin-left: 20px;"> <tr> <td style="border: none;">Size of Basement</td> </tr> <tr> <td style="border: none;"></td> </tr> </table>	Size of Basement																															
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6. Area(s) to be Used for Service(s) <table border="1" style="width: 100%; border-collapse: collapse; font-size: small;"> <thead> <tr> <th style="width: 15%;">Area</th> <th style="width: 10%;">Floor #</th> <th style="width: 10%;">Sq. Ft.</th> <th style="width: 10%;">Floor #</th> <th style="width: 10%;">Sq. Ft.</th> <th style="width: 10%;">Floor #</th> <th style="width: 10%;">Sq. Ft.</th> <th style="width: 10%;">Floor #</th> <th style="width: 10%;">Sq. Ft.</th> <th style="width: 10%;">Floor #</th> <th style="width: 10%;">Sq. Ft.</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>No. Exits</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </tbody> </table>	Area	Floor #	Sq. Ft.	Floor #	Sq. Ft.	Floor #	Sq. Ft.	Floor #	Sq. Ft.	Floor #	Sq. Ft.												No. Exits										
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No. Exits																																	
7. Services/Utilities <table style="width: 100%; font-size: small;"> <tr> <td style="width: 33%; vertical-align: top;"> a. Water Supply <input type="checkbox"/> Well <input type="checkbox"/> Municipal System <input type="checkbox"/> Other: _____ </td> <td style="width: 33%; vertical-align: top;"> b. Sanitary System <input type="checkbox"/> Septic <input type="checkbox"/> Municipal Sewer System <input type="checkbox"/> Other: _____ </td> <td style="width: 33%; vertical-align: top;"> c. Power <input type="checkbox"/> Gas <input type="checkbox"/> Oil <input type="checkbox"/> Electric <input type="checkbox"/> Other: _____ </td> </tr> </table>	a. Water Supply <input type="checkbox"/> Well <input type="checkbox"/> Municipal System <input type="checkbox"/> Other: _____	b. Sanitary System <input type="checkbox"/> Septic <input type="checkbox"/> Municipal Sewer System <input type="checkbox"/> Other: _____	c. Power <input type="checkbox"/> Gas <input type="checkbox"/> Oil <input type="checkbox"/> Electric <input type="checkbox"/> Other: _____																														
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1. Zoning Classification <table style="float: right; border: none; margin-left: 20px;"> <tr> <td style="border: none;">2. Proposed Use Conforms with Classification?</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	2. Proposed Use Conforms with Classification?	<input type="checkbox"/> Yes <input type="checkbox"/> No																															
2. Proposed Use Conforms with Classification?																																	
<input type="checkbox"/> Yes <input type="checkbox"/> No																																	
3. Outline below any community concerns, issues or opposition that have been raised or can reasonably be anticipated, including comments received from any local governmental planning body or NYC Community Board.																																	
4. Proximity to Nearest Community Facility (e.g., School, Religious Center, Child Care Facility) miles Type of Facility _____																																	
5. Building Classification																																	
6. Certificate of Occupancy Include as ATTACHMENT # 12 a copy of the Certificate of Occupancy. If not available, provide documentation from appropriate regulatory authority.																																	
P 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 building or in the immediate vicinity.																																

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PART IV – RESOURCE ALLOCATION

APPLICANT'S LEGAL NAME	
SITE	SERVICES

NOTE: PREPARE PART IV FOR EACH PROPOSED NEW SERVICE AT EACH SITE

	BUDGET ITEM DESCRIPTION	PROPOSED OPERATING BUDGET	
		Pre-Operational	Annual
A 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		
B REVENUES	Client/Patient Fees		
	Temporary Assistance to Needy Families – TANF <i>(Formerly AFDC)</i>		
	Safety Net Assistance – SNA <i>(Formerly Home Relief)</i>		
	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: <i>(List Source and Amounts)</i>		
	Total Revenues		
C PROFIT/(DEFICIT)	Total Expenses less Total Revenues		
D SOURCES OF DEFICIT FINANCING, IF ANY	OASAS State Aid		
	Other Deficit Funding Sources: <i>(List Sources and Amounts)</i>		
E BUDGET ASSUMPTIONS	<p><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></p>		
F FINANCIAL CONDITION OF APPLICANT	<p>Availability of Most Recent Financial Reports <i>(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.)</i></p> <p><input type="checkbox"/> Independently Audited Annual Financial Statement – Years Available: _____</p> <p><input type="checkbox"/> IRS Form 990 (Not-for-Profit Entities Only) – Years Available: _____</p> <p><input type="checkbox"/> Entity Annual Financial Statements (Unaudited Balance Sheet and Income Statement) – Years Available: _____</p> <p><i>Include as ATTACHMENT #22 a copy of the annual financial statements/reports for the three years specified above per instructions. If none of the above statements/reports are available, include most recent tax returns and/or a pro-forma balance sheet per instructions. (See Exhibit D, Page 53 of the instructions.) In addition, if the applicant has existed for less than three years, indicate the type of reports available among the above choices, and attach all reports available since the creation of the entity.</i></p>		

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PART IV – RESOURCE ALLOCATION (CONT'D)

APPLICANT'S LEGAL NAME											
SITE/ADDITIONAL LOCATION ADDRESS <input type="checkbox"/> Not Yet Selected					SERVICES						
G STAFFING		List below, by job title, all staff positions (to be) assigned to the proposed new or expanded service. Under "No. of FTEs" enter the total number of full-time equivalent staff in each job title. Under "No. 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. If staff are to be deployed to additional locations complete Appendix II – Staff Deployment Matrix for each affected site and service that provides outpatient services.									
Actual Job Title					No. of FTEs	No. of QHPs	Planned Staff Deployment (No. to be Assigned to Each Shift)				
<i>Include as ATTACHMENT #23 job descriptions for each job title listed.</i>							Days	Eves.	Nights	Weekends	
MANAGEMENT	Director of Services										
	Medical Director (If Any)										
	Other										
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: **Medical Services** – Physician, Psychiatrist, Nurse Practitioner, Physician's Assistant; **Nursing Services** - RN, LPN; **Counseling Services** – CASAC, Family Therapist, Psychologist, Social Worker, Counselor; **Rehabilitation Services** - Occupational Therapist, Rehabilitation Counselor, Therapeutic Recreation Therapist; **Other** – Acupuncturist.

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PART V – SERVICE CAPACITY INCREASES IF APPLICABLE AND TRANSFER OF OWNERSHIP

APPLICANT'S LEGAL NAME	
SITE ADDRESS	SERVICE

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	<i>Check all that apply</i> <input type="checkbox"/> Increase in Capacity <i>(Go to B. below)</i>		
		<input type="checkbox"/> Transfer the Above Service from: _____ <i>(Go to C. Below)</i> Name of OASAS Provider		
B	SERVICE CAPACITY INCREASE	1. Capacity Data 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"/> Decrease by _____ Patient Days/Visits <input type="checkbox"/> Increase by _____ Patient Days/Visits			
3. Staffing				
<input type="checkbox"/> None <input type="checkbox"/> Decrease* by _____ FTEs <input type="checkbox"/> Increase* by _____ FTEs				
*List FTE staffing changes below:				
		<u>Job Title</u>	<u>Existing FTEs</u>	<u>Revised FTEs</u>
			<u>Net Change (+/-)</u>	
D	FINANCIAL COMMITMENTS	Financial Commitments to Support Actions Requiring Additional Staff/Space <i>(Mark all that apply)</i> <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>		