

**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"/> Minor Relocation <input type="checkbox"/> Transfer of Ownership <input type="checkbox"/> New Treatment Service <input type="checkbox"/> Additional Location <input type="checkbox"/> Relocation/Space Expansion <input type="checkbox"/> Capital Project <input type="checkbox"/> Capacity Increase <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(s) 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(s) must include a signed and dated statement authorizing the proposed action.			
2. Certification of Finder's 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		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		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		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 official(s).								
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 II – SITE INFORMATION

Applicant's Legal Name						
A. Address of Existing/Proposed Site (For Additional Location see Section C)	Building/Building No. <input type="checkbox"/> 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. <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island		Board No.
B. Action Proposed	<input type="checkbox"/> Expand an Existing Site (Proceed to Section D) <input type="checkbox"/> Establish a New Site (Proceed to Section D) <input type="checkbox"/> Relocate to Another Site (Proceed to Section D) <input type="checkbox"/> Establish an Additional Location Associated with the above Site (Proceed to Section C)					
C. Address of Additional Location	Building/Building No. <input type="checkbox"/> 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. <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island		Board No.
D. Property Acquisition	Acquisition Status for this Site or Additional Location, as appropriate <input type="checkbox"/> Currently Owned by Applicant <input type="checkbox"/> Currently Leased by Applicant <input type="checkbox"/> Proposed Purchase <input type="checkbox"/> Proposed Lease (Proceed to Section G) <i>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.</i>					
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: <input type="checkbox"/> 1. Governing authority member, officer, stockholder or employee or <input type="checkbox"/> 2. Any relative of a governing authority member, officer, stockholder or employee or <input type="checkbox"/> 3. Any other entity of which a governing authority member, officer, stockholder or employee is a member. <input type="checkbox"/> 4. Not applicable <i>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.</i>					
G. Capital Investment Needs of Property	Indicate if the property acquired (will require) rehabilitation or construction work. <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Capital Financing by the Applicant (Proceed to Item 2 c & d below) <input type="checkbox"/> 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: <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 H now or later when the capital project is nearing completion. <input type="checkbox"/> Complete Section H now <input type="checkbox"/> Complete Section H later (2) If "Yes", complete Section H.					

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(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)		3. Sources of Capital Project Financial Support												
		Cost Item	Amount	Source	Amount											
		a. Site Acquisition	\$	a. OASAS	\$											
		b. Construction/Renovation		b.												
		c. Design		c.												
		d. Equipment		d.												
		e. Other (specify)		e.												
		Total Estimated Cost			Total Estimated Financing \$											
		4.	Proposed Construction Start Date													
I. Check the items that apply and, as appropriate, submit required documents. <ul style="list-style-type: none"> <input type="checkbox"/> a. This site or additional location has not yet received OASAS approval for chemical dependence treatment services by the applicant. <input type="checkbox"/> b. Structural and/or floor plan changes are being made by the applicant to this previously OASAS-approved site or additional location. <input type="checkbox"/> c. This application does not involve structural or floor plan changes that require OASAS approval. <p style="font-size: small; margin-top: 5px;"><i>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.</i></p>																
J. Select the setting, as described in the instructions, in which the site or additional location is (will be) situated. <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Community</td> <td style="width: 33%;"><input type="checkbox"/> Other Health Facility</td> <td style="width: 33%;"><input type="checkbox"/> OCFS Facility</td> </tr> <tr> <td><input type="checkbox"/> Hospital – On Premises</td> <td><input type="checkbox"/> Mental Health Facility</td> <td><input type="checkbox"/> School</td> </tr> <tr> <td><input type="checkbox"/> Hospital – Off Premises</td> <td><input type="checkbox"/> FQHC</td> <td><input type="checkbox"/> Shelter</td> </tr> <tr> <td><input type="checkbox"/> Shelter Plus Care Housing</td> <td colspan="2"><input type="checkbox"/> Other (specify) _____</td> </tr> </table>					<input type="checkbox"/> Community	<input type="checkbox"/> Other Health Facility	<input type="checkbox"/> OCFS Facility	<input type="checkbox"/> Hospital – On Premises	<input type="checkbox"/> Mental Health Facility	<input type="checkbox"/> School	<input type="checkbox"/> Hospital – Off Premises	<input type="checkbox"/> FQHC	<input type="checkbox"/> Shelter	<input type="checkbox"/> Shelter Plus Care Housing	<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Community	<input type="checkbox"/> Other Health Facility	<input type="checkbox"/> OCFS Facility														
<input type="checkbox"/> Hospital – On Premises	<input type="checkbox"/> Mental Health Facility	<input type="checkbox"/> School														
<input type="checkbox"/> Hospital – Off Premises	<input type="checkbox"/> FQHC	<input type="checkbox"/> Shelter														
<input type="checkbox"/> Shelter Plus Care Housing	<input type="checkbox"/> Other (specify) _____															
K. OASAS Physical Plant Inspections Check yes or no if OASAS has conducted a physical plant inspection for this site/additional location. <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", indicate the date of the most recent inspection and proceed to Part III. _____																
L. Indicate if the chemical dependence services at this site will share space with other providers of human services. <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", describe below plans to set aside discrete space for chemical dependence services as well as plans for utilizing shared space.																
Shared Space Issues																

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(Read Instructions Carefully Before Completion)

PART II – SITE INFORMATION (Continued)

Applicant's Legal Name							
M. 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 (Specify) _____						
	2. Exterior Walls <input type="checkbox"/> Aluminum <input type="checkbox"/> Clapboard <input type="checkbox"/> Masonry <input type="checkbox"/> Other (Specify) _____						
	3. Foundation <input type="checkbox"/> Poured Concrete <input type="checkbox"/> Concrete Block <input type="checkbox"/> Other (Specify) _____						
	4. Building <input type="checkbox"/> Fully Attached <input type="checkbox"/> Semi Attached <input type="checkbox"/> Freestanding				Building Size Sq. Ft.	# of Floors (exclude Basement)	
	5. Basement <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", will it be used for patient services? <input type="checkbox"/> Yes <input type="checkbox"/> No					Size of Basement Sq. Ft.	
	6. Area(s) to be used for Service(s)						
	Area	Floor #	Floor #	Floor #	Floor #	Floor #	Floor #
		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			
<input type="checkbox"/> Well <input type="checkbox"/> Municipal System		<input type="checkbox"/> Septic <input type="checkbox"/> Municipal Sewer System		<input type="checkbox"/> Gas <input type="checkbox"/> Oil <input type="checkbox"/> Electric			
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____			
N. Local Planning Requirements	1. Zoning Classification		2. Proposed use Conforms with Classification <input type="checkbox"/> Yes <input type="checkbox"/> 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.						

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PART II – SITE INFORMATION (Continued)

Applicant's Legal Name	
P.	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. <input type="checkbox"/> Yes <input type="checkbox"/> No
Accessibility to Disabled	
Q.	<ol style="list-style-type: none"> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Is the Site/Additional Location substantially contiguous to a site listed in the Register of Natural Landmarks? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Is the Site/Additional Location in a state Coastal Zone Management Area (CZM)? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Is the Site/Additional Location in a State or Local Critical Environment Area (CEA)? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. The proposed Site/Additional Location will require: <ul style="list-style-type: none"> <input type="checkbox"/> a planning or zoning change <input type="checkbox"/> a zoning variance <input type="checkbox"/> a special use permit <input type="checkbox"/> a site plan approval <input type="checkbox"/> none of the preceding 6. Does the Site/Additional Location have an adequate and safe water supply and wastewater disposal system? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Does the Site/Additional Location involve ten or more acres of property? <input type="checkbox"/> Yes <input type="checkbox"/> No 8. Discuss below any other environmental issues which may be reasonably anticipated at this Site/Additional Location.
Historical/ Environmental Significance of this Site or Additional Location (as appropriate)	
R.	Does the proposed relocation affect the current operating budget or capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relocation Only	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

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>			

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 <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.

