

**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 <b>NY</b>	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

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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**APPLICATION SUMMARY**

Applicant's Legal Name								
<b>Application Contact Person</b>								
Name of Contact Person					Position/Affiliation with Applicant			
Address (Street, City, State, Zip Code)								
Telephone Number			Fax Number			E-Mail Address		
<b>Local Support</b>								
Include as <b>Attachment #2A</b> , 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		
<b>Identification of Sites and Services Affected by this Application</b>								
<input type="checkbox"/> None <input type="checkbox"/> As Detailed Below								
<b>Site #1</b>	Site Address <input type="checkbox"/> Not Yet Selected <b>(New Providers Only)</b>							
	<b>Services</b>	<b>Status</b>	<b>Persons Served Annually</b>	<b>Capacity</b>		<b>Units of Service</b>		<b>OASAS Cert. No.*</b>
		<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						
<b>Site #2</b>	Site Address <input type="checkbox"/> Not Yet Selected <b>(New Providers Only)</b>							
	<b>Services</b>	<b>Status</b>	<b>Persons Served Annually</b>	<b>Capacity</b>		<b>Units of Service</b>		<b>OASAS Cert. No.*</b>
		<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						
<b>Site #3</b>	Site Address <input type="checkbox"/> Not Yet Selected <b>(New Providers Only)</b>							
	<b>Services</b>	<b>Status</b>	<b>Persons Served Annually</b>	<b>Capacity</b>		<b>Units of Service</b>		<b>OASAS Cert. No.*</b>
		<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



NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES  
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(Read Instructions Carefully Before Completion)

**PART I – ENTITY INFORMATION**

Applicant’s Legal Name

<b>F.</b>	<p>List all current members of the Governing Authority</p> <p>As appropriate to the type of entity, provide information below on: (1) each individual owner, (2) each partner of a partnership or limited liability partnership, (3) each member of the board of directors of a not-for-profit corporation or (4) each governing body member or holder of voting rights of a business corporation or limited liability company <b>and</b> each principal stockholder (i.e., non-governing body stockholder controlling 10% or more of the stock) of the business corporation or limited liability company.</p> <p><b>Each governing authority member/principal stockholder listed must complete, sign and date the Governing Authority Questionnaire provided in Appendix I.</b></p>						
<b>Entity Governing Authority and Principal Stockholders  (Non- Governmental Entities Only)</b>	Name of Member (M) and/or Principal Stockholder (S)	M or S	Social Security #  or Employer ID #.	Required for Members/Principal Stockholders of Business Corporations/LLCs Only			
	<b>Note: A check mark in the box indicates inclusion of the Governing Authority Questionnaire</b>			Stock Held or Share of Distributions		Voting Rights Held	
				Shares Held	Percent	Amount	Percent

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES**  
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(Read Instructions Carefully Before Completion)

**PART II – SITE INFORMATION**

Applicant's Legal Name						
<b>A. Address of Existing/Proposed Site</b>  (For Additional Location see Section C)	Building/Building No. <input type="checkbox"/> Not Yet Selected ( <b>New Providers Only</b> )			Room/Suite	Floor	PO Box/Postal Route
	Street		City, Town, Village	State <b>NY</b>	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>B. Action Proposed</b>	<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)					
<b>C. Address of Additional Location</b>	Building/Building No. <input type="checkbox"/> Not Yet Selected			Room/Suite	Floor	PO Box/Postal Route
	Street		City, Town, Village	State <b>NY</b>	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>D. Property Acquisition</b>	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 <b>ATTACHMENT #8</b> 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>					
<b>E. Source of Funds for Purchase or Lease</b>	Source	OASAS				
	Dollar Amount	\$	\$	\$	\$	
<b>F. Real Property Interest of Applicant</b>	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 <b>ATTACHMENT #9</b> 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>					
<b>G. Capital Investment Needs of Property</b>	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 <b>ATTACHMENT #10</b> , 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							
<b>M.</b>          <b>Property Characteristics</b>	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 _____			
<b>N.</b>  <b>Local Planning Requirements</b>	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 <b>ATTACHMENT #12</b> 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.						
<b>O.</b>          <b>Area Characteristics</b>	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.						

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES**  
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**PART II – SITE INFORMATION (Continued)**

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

(Read Instructions Carefully Before Completion)

**PART III – DESCRIPTION OF SERVICES**

Applicant's Legal Name	
Site/Additional Location Address <input type="checkbox"/> Not Yet Selected ( <b>New Providers Only</b> )	Service Type
<b>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.</b>	
<b>A.</b>	Indicate the type of site action applicant is requesting.
<b>Action Proposed</b>	<ul style="list-style-type: none"> <li>a.   <input type="checkbox"/> Provide a new service at this site</li> <li>b.   <input type="checkbox"/> Establish a service at an additional location at a <b>stand-alone location</b> (Outpatient Services Only)</li> <li>c.   <input type="checkbox"/> Establish a service at an additional location at <b>host agency</b> (Outpatient Services Only)</li> </ul> <p><i>If "at host agency", provide as <b>ATTACHMENT #13</b> a description of the arrangements and reasons for establishing the additional location at the host agency.</i></p>
<b>B.</b>	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.
<b>Description of Area to be Served</b>	
<b>C.</b>	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.
<b>Assessment of Need</b>	Include as <b>ATTACHMENT #14</b> information relative to need as specified in the instructions.
<b>D.</b>	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.
<b>Description of Services</b>	2. List and define the specific service components to be offered to patients, including any proposed time-structured treatment regimen or module. Include as <b>ATTACHMENT # 15</b> the description of service components requested per instructions.
	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 <b>ATTACHMENT # 16</b> the description of goals and objectives, per instructions.

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES  
OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION**

(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					
<b>E.  Special Populations</b>	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.														
<b>F.  Proposed Operating Schedule (Specify a.m. or p.m.)</b>	<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*														
<b>*Opioid Treatment Services Only</b>															
<b>G. Projected Workload</b>	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)														
<b>H.  Operational Policies and Procedures</b>	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. <a href="#">Guidance for writing policies and procedures</a> can be found on the <a href="#">OASAS website</a> . The applicant must develop and submit as <b>Attachment #17</b> detailed chemical dependence operational policies and procedures in accord with proposed services to be provided, <b>including but not limited to</b> :  (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 <b>medically managed detoxification, medically supervised withdrawal and medically monitored withdrawal services</b> , 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.															
<b>NOTE: For new opioid services, complete remaining Sections I-O of Part III; for other new services, proceed to Part IV.</b>															

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES**  
**OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION**

(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 <b>(New Providers Only)</b>			Service <b>Opioid Treatment</b>		
<b>I. Key Opioid Program Staff</b>	Chief Executive Officer		Medical Director		
	Site Medical Director		Other (Specify)		
<b>J.  Program Approval Status</b>	<b>Application    Submitted    Approved    Other</b>				
	Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment (CSAT)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Drug Enforcement Administration		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	NYS Department of Health		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Include as <b>ATTACHMENT # 19</b> a copy of each application the applicant has submitted or other evidence that the approval process is in progress or that approval has been granted.</i>					
<b>K.  Alternative Emergency Medication Procedures</b>	1. Describe arrangements for the medication of patients during emergency or holiday situations when the clinic is unable to open.				
	2. Indicate if the above arrangements are consistent with CSAT Guidelines. <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>L.          Methadone Security</b>	1. Storage Arrangements				
	<input type="checkbox"/> On-Site (Complete #2 below)		<input type="checkbox"/> Off-Site Location (Complete #3 below)		
	2. Describe the alarm system and other security measures for on-site methadone storage.				
3. Describe security measures for the transport of methadone to and from the central pharmacy location.					

**NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES  
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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 <b>Opioid Treatment</b>	
<b>M.</b>          <b>Staffing</b>	<b>Staff Position</b>	<b>Name</b>	<b>License No.</b>	<b># Days on Site</b>	<b>Daily Hours on Site</b>
	Physician				
	Physician's Assistant(s)				
	Nurse Practitioner(s)				
	Nurse(s)				
	LPN(s)				
	Counselor(s)				
	Clinic Supervisor				
	Pharmacist(s)				
	Other				
<b>N.</b>          <b>Responsiveness to Community Concerns</b>	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.				
<b>O.</b>          <b>Treatment Services</b>	Describe treatment services in detail. This description supplements the description of treatment services previously covered in Section D. <b>Important: Subject matter to be covered is listed in the instructions.</b>  <i>Include as ATTACHMENT #20 a description of treatment services.</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 Address		Service Type	
<b>Prepare Part IV for each proposed new service at each site</b>			
A.	Budget Item Description	Proposed Operating Budget	
		Pre-Operational	Annual
<b>Revenues</b>	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)		
		<b>Total Revenues</b>	
<b>Expenses</b>	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)		
		<b>Total Expenses</b>	
<b>C. Profit/(Deficit)</b>	<b>Total Revenues less Total Expenses</b>		
<b>Sources of Deficit Financing, If Any</b>	OASAS State Aid		
	Other Deficit Funding Sources (List Sources and Amounts)		
<b>E. Budget Assumptions</b>	<i>Include as <b>Attachment #21</b> 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>		
<b>Financial Condition of Applicant</b>	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 <b>Attachment #22</b> 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.

# NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

## OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

For each job title listed on Page 2, identify the proposed work hours as prescribed in regulatory standards (specify a.m. or p.m.) Use one line per employee and one page per affected site.

H.	Proposed Work Schedule													
	Is the proposed service open 24 hours per day, 7 days per week? <input type="checkbox"/> Yes <input type="checkbox"/> No													
	Job Title	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday
From		To	From	To	From	To	From	To	From	To	From	To	From	To

**Example**

H.	Proposed Operating Schedule													
	Is the proposed service open 24 hours per day, 7 days per week? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	Job Title	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday
From		To	From	To	From	To	From	To	From	To	From	To	From	To
Program Director	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.	9 a.m.	5 p.m.				
Counselor (CASAC)	9 a.m.	5 p.m.	9 a.m.	5 p.m.			1 p.m.	9 p.m.	1 p.m.	9 p.m.	8 a.m.	12 p.m.		
Counselor I			4 p.m.	8 p.m.	4 p.m.	8 p.m.	4 p.m.	8 p.m.	4 p.m.	8 p.m.	8 a.m.	12 p.m.		

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES  
**OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION**

(Read Instructions Carefully Before Completion)

**APPENDIX I – GOVERNING AUTHORITY QUESTIONNAIRE**

Applicant's Legal Name				
<b>Personal Information</b>				
Name of Governing Authority Member/Principal Stockholder		Title or Affiliation with Entity		Business or Profession
Street Address/PO Box			Date of Birth	Place of Birth
City, Town, Village			State and Zip Code +4	Telephone Number
<b>A.  Current Professional Credentials (Certificate and Licenses Held)</b>	Profession	Certificate/License No.	Profession	Certificate /License No.
	Grantor Agency	City or State of	Grantor Agency	City or State of
	Specialty	Date Issued	Specialty	Date Issued
	Term (Month/Day/Year)		Term (Month/Day/Year)	
	From:	To:	From:	To:
<p>Have you ever been the subject of a complaint or inquiry before any board, agency committee, regulatory body or licensing authority regarding professional misconduct?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><i>If "Yes", prepare and append an attachment labeled "Section A", which describes the circumstances of the complaint or inquiry. Include, at a minimum, the date of the incident/episode, the type of complaint or subject of the inquiry, and the person(s) and/or facilities involved, and the disposition of the matter. Provide any further details that materially relate to the incident/episode.</i></p>				
<b>B.  Formal Education Beyond High School (if applicable)</b>	Dates Attended (Month/Year)		Name and Location of Institution	Degree (if any)
	From	To		
<b>C.  Employment History (Covering the Past 10 Years)</b>	Dates (Month/Year)		Name and Location of Employer	Title/Position
	From	To		

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES  
**OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION**

(Read Instructions Carefully Before Completion)

**APPENDIX I – GOVERNING AUTHORITY QUESTIONNAIRE (CONTINUED)**

Applicant's Legal Name					
Name of Member/Stockholder					
<b>D.</b>  <b>Chemical Dependence, Health &amp; Human Services Clinical/ Administrative Education and Training</b>	As outlined in Part 810 – Certification of Providers of Chemical Dependence Services of the OASAS Operating Regulations, specifically Section 810.7(a)(6), owners or principals of the applicant must demonstrate and substantiate prior experience providing or managing substance use disorder treatment services.				
	<b>Dates Attended (Month/Year)</b>		<b>Type of Training/Course Name</b>	<b>Name/Location of Training Institution</b>	<b>Hours Credited</b>
	<b>From</b>	<b>To</b>			
<b>E.</b>  <b>Governing Authority Member/Principal Stockholder Interest in an Entity Currently (or to be) Regulated by a NYS Agency</b>	<b>Dates (Month/Year)</b>		<b>Name and Location of Entity</b>	<b>Interest Held</b>	
	<b>From</b>	<b>To</b>			
<b>F.</b>  <b>Record of Legal Action</b>	1. Have you ever been convicted of a felony? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
	2. Are there any criminal actions pending against you or other members of a governing authority of an organization in which you have an interest? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
3. Have you ever been a party to or involved in a hearing on the operation of a home, facility or institution caring for people before a court or administrative agency of government? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
If the answer to any of the above questions is <b>“Yes”</b> , prepare and append an attachment labeled <b>“Section F”</b> to this form, which describes the conviction and/or charges. Include, at a minimum, the date of the incident, the type of offense or subject of the hearing, and the person(s) and/or facilities involved, and the disposition of the matter. Provide any further details that materially relate to the incident/episode. Include with the attachment a copy of the <b>“Certificate of Relief from Disabilities”</b> or <b>“Certificate of Good Conduct”</b> or other notice of change in the disposition.					
<b>G.</b>  <b>Certification, Consent to Release Information and Signature</b>	<p>I certify, under penalty of perjury, that the information presented in this form is accurate, true and complete in all material aspects. Furthermore, in signing this document, I hereby authorize the above-named grantor agencies, schools, training institutions, employers, facilities, administrative entities and/or courts to release to the Office of Alcoholism and Substance Abuse Services any and all information regarding my credentials, education and training, employment, offices held and legal proceedings.</p> <p style="text-align: center;"> <span style="display: inline-block; width: 45%; border-bottom: 1px solid black; margin-bottom: 5px;"></span> <span style="display: inline-block; width: 45%; border-bottom: 1px solid black; margin-bottom: 5px;"></span> </p> <p style="text-align: center;"> <span style="display: inline-block; width: 45%; margin-bottom: 5px;">Signature of Governing Authority Member/Principal Stockholder</span> <span style="display: inline-block; width: 45%; margin-bottom: 5px;">Date</span> </p>				

# OASAS CHEMICAL DEPENDENCE CERTIFICATION APPLICATION

## Appendix IV Character and Competence Applicant Review

**INSTRUCTIONS**

**Completion and Certification:** The person(s) completing the questionnaire must be knowledgeable about the Applicant's business and operations. An owner or officer must certify this questionnaire and the signature must be notarized.

**Responses:** Every question must be answered. Each response must provide all relevant information which can be obtained within the limits of the law.

**Applicant Entity:** Each Applicant must indicate if the questionnaire is filed on behalf of the proposed operator of an OASAS-certified facility or as a subsidiary of another business entity.

**Closely Allied Entities:** A "Closely Allied Entity" is an entity as defined in Section 25.06(c) of the Mental Hygiene Law.

### I. Applicant Information

<b>1.0</b>	The Applicant for this questionnaire is: <input type="checkbox"/> a. the proposed OASAS-certified facility operator, or <input type="checkbox"/> b. a business entity which exercises governance authority over another legal business entity which will be the proposed OASAS-certified facility operator.  c. Describe the lines of authority or attach an organizational chart.   Applicant's Legal Name
<b>1.1</b>	Does the Applicant have any Affiliates? <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, proceed to Question # 1.9; if yes, explain ( <i>attach a separate sheet, if necessary, identifying the numbered response, include the Applicant's name on all sheets</i> ).
<b>1.2</b>	Affiliate's Name
<b>1.3</b>	Affiliate's EIN
<b>1.4</b>	Affiliate's Primary Business Activity
<b>1.5</b>	Explain relationship with the Affiliate and indicate percent ownership, if applicable. (Enter N/A if not applicable) _____ %
<b>1.6</b>	Are there any business entity officials or principal owners that the Applicant has in common with this Affiliate? <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, explain.
<b>1.7</b>	If yes to Question # 1.6, provide the individual's name

1.8	If yes to Question # 1.6, provide the individual's Position/Title with Affiliate.
1.9	Does the Applicant have any Closely Allied Entities as defined in Mental Hygiene Law §25.06(c)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, proceed to Question # 1.13)
1.10	<p>Within the past five (5) years, has any Closely Allied Entity Official or Principal Owner been charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a judgment for:</p> <p>a) any business-related activity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) any crime, whether or not business-related, the underlying conduct of which was related to truthfulness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes to either a) or b), attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), the individual involved, his/her title and role in the Closely Allied Entity, his/her relationship to the Applicant, relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s).</i></p>
1.11	<p>Does any Closely Allied Entity have any currently undischarged federal, New York State, New York City or New York local government liens or judgments (not including UCC Filings) over \$25,000? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide an explanation of the issue(s), identify the Closely Allied Entity's name(s), EIN(s), primary business activity, relationship to the Applicant, relevant dates, the Lien holder or Claimant's name(s), the amount of the lien(s) and the current status of the issue(s). Attach additional sheets if necessary; ensure all answers are clearly marked and include the Applicant's name on each additional sheet.</p>
1.12	<p>Within the past five years, has any Closely Allied Entity:</p> <p>a) been disqualified, suspended or debarred from any federal, State, City or other local government contracting process? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) been denied a contract award or had a bid rejected based upon a non-responsibility finding by any federal, New York State, New York City or New York local government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c) been suspended, cancelled or terminated for cause (including for non-responsibility) on any federal, New York State, New York City or new York local government contract? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d) been the subject of an investigation, whether open or closed, by any federal, New York State, New York City or New York local government entity for a civil or criminal violation with a penalty in excess of \$500,000? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e) been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f) been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any federal, New York State, New York City or New York local government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g) initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>For each yes answered above, attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), identify the Closely Allied Entity's name(s), EIN(s), primary business activity, relationship to the Applicant, relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s).</i></p>
1.13	<p>Will any of the proposed in this application be provided by an organization other than the Applicant through a management services contract, employment contract or clinical services contract? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide an explanation of the contract(s), including the names of the individuals or entities providing the services. Attach a separate sheet, if necessary, identifying each numbered response and include the Applicant's name on all sheets.</p>



### IV. Integrity – Contract Bidding

<b>4.0</b>	Within the past five (5) years, has the Applicant held any contracts with New York State government entities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify the Contract Number, Agency Name, Amount, Contract Start Date, Contract End Date and the Contract Description.
<b>4.1</b>	Within the past five (5) years, has the Applicant been suspended or debarred from any government contracting process or been disqualified on any government procurement, permit, license, concession, franchise or lease, including, but not limited to debarment for a violation of New York State Workers' Compensation or Prevailing Wage laws or New York State Procurement Lobbying Law? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.2</b>	Within the past five (5) years, has the Applicant been subject to a denial or revocation of a government prequalification? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.3</b>	Within the past five (5) years, has the Applicant been denied a contract award or had a bid rejected based upon a non-responsibility finding by a government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.4</b>	Within the past five (5) years, has the Applicant agreed to a voluntary exclusion from bidding/contracting with a government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4.5</b>	Within the past five (5) years, has the Applicant initiated a request to withdraw a bid submitted to a government entity in lieu of responding to an information request or subsequent to a formal request to appear before the government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No

*For each yes answer for Question #'s 5.0 – 5.2, attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issues(s).*

### V. Integrity – Contract Award

<b>5.0</b>	Within the past five (5) years, has the Applicant or any Affiliate of Applicant been suspended, cancelled or terminated for cause on any government contract including, but not limited to, a non-responsibility finding? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5.1</b>	Within the past five (5) years, has the Applicant or any Affiliate of Applicant been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5.2</b>	Within the past five (5) years, has the Applicant or any Affiliate of Applicant entered into a formal monitoring agreement as a condition of a contract award from a government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No

*For each yes answer for Question #'s 4.0 – 4.5, attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s).*

### VI. Certifications/Licenses

<b>6.0</b>	Within the past five (5) years, has the Applicant or any Affiliate of Applicant had a revocation, suspension or disbarment of any business or professional permit and/or license? <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>If yes, attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s).</i>
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### VII. Legal Proceedings

<b>7.0</b>	Within the past five (5) years, has the Applicant been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>7.1</b>	Within the past five (5) years, has the Applicant been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime? <input type="checkbox"/> Yes <input type="checkbox"/> No

7.2	Within the past five (5) years, has the Applicant received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful? <input type="checkbox"/> Yes <input type="checkbox"/> No
7.3	Within the past five (5) years, has the Applicant had a government entity find a willful prevailing wage or supplemental payment violation or any other willful violation of New York State Labor Law? <input type="checkbox"/> Yes <input type="checkbox"/> No
7.4	Within the past five (5) years, has the Applicant entered into a consent order with the New York State Department of Environmental Conservation or received an enforcement determination by any government entity involving a violation of federal, state or local environmental laws? <input type="checkbox"/> Yes <input type="checkbox"/> No
7.5	Within the past five (5) years, has the Applicant, other than previously disclosed: a) been subject to the imposition of a fine or penalty in excess of \$1,000, imposed by any government entity as a result of the issuance of citation, summons or notice of violation, or pursuant to any administrative, regulatory, or judicial determination? <input type="checkbox"/> Yes <input type="checkbox"/> No b) been charged or convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity? <input type="checkbox"/> Yes <input type="checkbox"/> No

For each yes answer for Question #'s 7.0 – 7.5, attach a separate sheet identifying each numbered response, include the Applicant's name on all sheets and provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s).

### VIII. Financial and Organizational Capacity

8.0	Within the past five (5) years, has the Applicant received any formal unsatisfactory performance assessment(s) from any government entity on any contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.1	Within the past five (5) years, has the Applicant had any liquidated damages assessed over \$25,000? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.2	Within the past five (5) years, have any liens or judgments (not including UCC filings) over \$25,000 been filed against the Applicant which remains undischarged? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.3	In the last seven (7) years, has the Applicant initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide a. the bankruptcy chapter number b. the court name c. the docket number. Current status of the proceedings <input type="checkbox"/> Initiated <input type="checkbox"/> Pending <input type="checkbox"/> Closed
8.4	During the past three (3) years, has the Applicant failed to file or pay any tax returns required by federal, state or local tax laws? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the taxing jurisdiction, the type of tax, the liability year(s), the tax liability amount the Applicant failed to file/pay and the current status of the tax liability.
8.5	During the past three (3) years, has the Applicant failed to file or pay any New York State unemployment insurance returns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the years the Applicant failed to file/pay the insurance, explain the situation and any remedial or corrective action(s) taken and the current status of the issue(s).
8.6	During the past three (3) years, has the Applicant had any government audit(s) completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, a. did any audit of the Applicant identify any reported significant deficiencies in internal control, fraud, illegal acts, significant violations of provisions of contract or grant agreements, significant abuse or any material disallowance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to Question # 8.6 a., attach a separate sheet, identifying the numbered response, and provide an explanation of the issue(s), relevant dates, the government entity involved, any remedial or correction action(s) taken and the current status of the issue(s).

## IX. Certification

The undersigned:

- 1) recognizes that this questionnaire is submitted for the express purpose of assisting New York State OASAS in making responsibility determinations regarding the certification of the Applicant as an authorized provider of chemical dependence services in New York;
- 2) recognizes that OASAS will rely on information disclosed in the questionnaire in making character and competence determinations and in approving the character and competence of potential providers of services;
- 3) acknowledges that OASAS may, in its discretion, by means which it may choose, verify the truth and accuracy of all statements made herein; and
- 4) acknowledges that intentional submission of false or misleading information may result in a finding of non-responsibility and unacceptable character and competence to grant an operating certificate.

The undersigned certifies that he/she:

- a. is knowledgeable about the Applicant's business and operations;
- b. has read and understands all of the questions contained in the questionnaire;
- c. has not altered the content of the questionnaire in any manner;
- d. has reviewed and/or supplied full and complete responses to each question;
- e. to the best of his/her knowledge, information and belief, confirms that the Applicant's responses are true, accurate and complete, including all attachments, if applicable;
- f. understands that OASAS will rely on the information disclosed in the questionnaire when deciding to certify the Applicant; and
- g. is under obligation to update the information provided herein to include any material changes to the Applicant's responses at the time application's submission through the notification of certification, and may be required to update the information at the request of OASAS prior to the granting of an operating certificate, or during the term of such certificate.

Signature of Applicant's Owner or Officer (Must be notarized)		Printed Name of Signatory	
Title of Signatory		Full Address (Street, City, State, Zip Code)	
Telephone Number	Fax Number	E-Mail Address	

Sworn to before me this \_\_\_\_\_ of \_\_\_\_\_ 20\_\_\_\_  
(Day) (Month) (Year)

Notary Public

<b>OASAS Criminal Background Check Unit, Counsel's Office 1450 Western Avenue Albany NY 12203 Fax: 518-485-2335 Email: cbc@oasas.ny.gov</b>	<b>CERTIFICATION Applicant Consent Form for Fingerprinting for OASAS Criminal Background Check (CBC)  (Appendix V)</b>	<b>NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES</b>
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**Part 1. Certification Applicant Information (Please Print)**

Last Name	First Name	MI
Date of Birth	Social Security Number	

Applicant address

Certification Application Type

New OASAS Provider     
 Transfer of Ownership     
 Change in Ownership Status

**Part 2. Attestation**

- I have been advised that as part of the application process, the law requires the NYS Office of Alcoholism and Substance Abuse Services (OASAS) to request a criminal history information check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and authorizes OASAS to review and evaluate the results of the criminal history information check received by DCJS and FBI. A conviction for certain crimes may make me ineligible for certification.
- I consent to having my fingerprints taken and submitted for the purpose of a criminal history information check to DCJS and the FBI and consent to OASAS reviewing the NYS and FBI criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for credentialing, or for certification as a natural person operator.
- I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
- I have been advised that I have the right to withdraw my application for credentialing or certification as a natural person operator, without prejudice, any time before credentialing or certification as a natural person operator is offered or declined, regardless of whether OASAS has reviewed any criminal history information.
- I have been advised that the results of the criminal history information check forwarded to OASAS by DCJS and the FBI shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making certification determinations.
- I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
- I certify to the best of my knowledge that I: (check as appropriate)
  - have been convicted of a crime in New York State or any other jurisdiction.
  - have pending arrest charges.

If checked, provide details:
- I have been advised that my social security number is being requested so that OASAS may check whether I am on the Staff Exclusion List which is maintained as part of the Vulnerable Persons' Central Registry and that such check is required by Social Services Law §495 and will be performed prior to the criminal history information check. 14 NYCRR Part 702 provides for the collection of social security numbers for this purpose and the failure to provide my social security number may preclude me from being considered for the certification applied for.

Applicant Signature	Date
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**Part 3. OASAS Authorized Person Information (For Office Use Only)**

Name	Title
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Signature