



**APPLICATION FOR CERTIFICATION  
ALCOHOL AND DRUG PROGRAMS**

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2. Copies of required information:

- (a) **Current and approved** fire inspection from the state or local Fire Marshal or local fire department for each site/satellite location
- (b) Organizational Chart with names and positions delineated
- (c) List of board members, including addresses and phone numbers, Bylaws, Certificate, and Articles of Incorporation; or limited liability company By laws and Certificate
- (d) Program Description
- (e) Official documentation (e.g., zoning board, city manager) affirming that the treatment facility is located in compliance with applicable zoning ordinances
- (f) **For new programs, programs certified after November 1, 2002, or programs relocating to a different address**, official documentation (e.g., school superintendent, school principal, school board, land surveyor) affirming that the treatment facility is not located within one thousand (1000) feet of any public AND private elementary AND secondary schools (**refer to Title 43A of the Oklahoma Statutes § 3-417.1**)
- (g) **For new programs only**, current Balance Sheet and Operating (Income and Expense) Statement

3.  I hereby request the ODMHSAS accept the national accreditation by JCAHO/CARF/COA/AOA as compliant with certain specific ODMHSAS standards. **Documentation MUST be included: current accreditation status, the programs included in the most recent accreditation survey, survey reports, reports of subsequent actions initiated by the accrediting organization, plans of correction if applicable, and the time period for which accreditation has been granted.**

4.  The applicant is an approved provider site under the STAR/NIATx project. Please submit official documentation from ODMHSAS verifying approval as a provider site.

5.  The applicant contracts with the Oklahoma Department of Corrections (DOC) to provide services to DOC consumers. Please indicate the percentage of DOC consumers served. (\_\_\_\_\_%)

J. I hereby assure that the applicant organization operates without discrimination as to race, color, gender, age, degree of disability, handicapping condition, veteran status, religion, or ethnic origin.

K. I acknowledge that the granting of certification by ODMHSAS is not a commitment from ODMHSAS to contract with this organization.

L. As an authorized representative of the applicant organization, I verify this application and attached documents are true and correct.

M. ***I acknowledge that my agency's certification review will be conducted under the ODMHSAS Standards and Criteria, effective July 11, 2008.***

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Authorized Program Official)

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**Mission: To Promote Healthy Communities and Provide the Highest Quality Care to Enhance the Well-Being of all Oklahomans**

1200 N.E. 13<sup>th</sup>., P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277 • (405) 522-3908 • (405) 522-3851 TDD • (405) 522-3650 FAX