

Oklahoma Department of Mental Health
and Substance Abuse Services

Oklahoma Access to Recovery (OATR) →

If you have questions or need assistance with completing this application, please contact:

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REQUEST FOR APPLICATION

The Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) requests applications from traditional, faith and community-based and other non-traditional providers of services to persons with substance use disorders. Services described in response to this Request for Application (RFA) shall support consumers' recovery from substance use disorders. Services described shall be recognized as Assessment, Treatment, and Recovery Support Services and provide services to eligible consumers in accordance with the federal Access to Recovery (ATR) program as described through the Oklahoma Access to Recovery (OATR) Program and detailed in the *OATR Participating Provider's Handbook*.

To be considered for designation as a provider of Assessment, Treatment, and/or Recovery Support Services in the OATR program, a provider must submit an application in compliance with the requirements described in this Request for Application and meet the eligibility requirements described in this Request.

Issuance of this Request in no way constitutes a commitment by DMHSAS or the State of Oklahoma to execute any Memorandum of Understanding (MOU) or to pay any costs incurred by any applicant in submitting an application. If DMHSAS enters into a MOU with a Provider, DMHSAS does not guarantee any referral or level of funding under the MOU.

The resulting MOU will be subject to the availability of federal funds. If funds for the MOU become unavailable during any budget period, or if DMHSAS is unable to obtain additional funds, the MOU may be immediately terminated at DMHSAS' discretion.

APPLICATION INSTRUCTIONS

1. Applicant Signature. Responses must contain **original** signatures on all forms requiring signatures. Signatures must be from an official appointed by the organization's governing body with the authority to bind the organization.
2. Application Preparation and Assembly. Complete and return all required forms to the address indicated below. A complete application consists of responses to all information listed in this document.
3. Applications must be sent to the following address:
Oklahoma Access to Recovery Program
Attention: Johnny J. Jones
DMHSAS
1200 NE 13th Street
Oklahoma City, OK 73117
4. Please do not submit application by facsimile (FAX) or electronic mail transmission (email).
5. Upon receipt, the application will be screened by OATR personnel. When all criteria have been met, a Memorandum of Understanding will be offered.

GENERAL INSTRUCTIONS FOR THE APPLICATION FACE PAGE

Complete the items listed below in Sections I & II:

1. a-j. Enter the legal name of the applicant organization and the business (DBA) name if appropriate. Enter the name of the person completing the application. Complete the address, county where the headquarters is located; fax number of the organization and the email address where official business correspondence can be directed. Enter the names and telephone numbers for the executive director, program director(s), financial contact and board chair.
2. Enter Employer Identification Number of applicant as assigned by the Internal Revenue Service.
3. Check the applicant type that best describes applicant organization. If "other," specify type of organization. Please check "faith-based" if you choose to identify your agency as such.
4. If an answer of yes is given for 4a, 4b, 4c, 4d, or 4e, please provide or attach an explanation.
5. Review application certification statement.
6. Enter name of Executive Director and original signature and date.
7. Enter name of Authorized Certifying Official (Board President, etc.), title, original signature, and date.

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APPLICATION FACE PAGE

**FY 2008 ACCESS TO RECOVERY
ASSESSMENT, TREATMENT AND/OR RECOVERY SUPPORT SERVICES**

ORGANIZATION/ENTITY INFORMATION

<p>1. Organization /Entity Name: DBA:</p> <p>a. Contact Person Regarding Application:</p> <p>b. Telephone number:</p> <p>c. Physical Address: Mailing Address:</p> <p>d. City, State, and ZIP</p> <p>e. County:</p>	<p>2. EMPLOYER IDENTIFICATION NUMBER (EIN):</p> <p>3. CHECK TYPE: ___ For-Profit ___ Nonprofit ___ Public</p> <p><input type="checkbox"/> “GRASS-ROOT” Provider--Grass-root providers are providers with an annual operating budget of \$500,000 or less; they may be faith-based or secular. The \$500,000 applies to <u>operating budget only, not including assets.</u></p> <p><input type="checkbox"/> Is the organization faith-based? If Yes, check one of the following: <input type="checkbox"/> Religious Affiliation: _____ <input type="checkbox"/> No specific religious affiliation, but still faith-based</p>
<p>f. Fax number:</p> <p>g. Email address for official communication:</p> <p>h. Executive Director/CEO (Name/Telephone Number):</p> <p>i. Financial Contact/CFO (Name/Telephone Number):</p> <p>j. Board Chair (Name/Address/Telephone Number):</p>	

4. If you answer yes to any of the following, provide a detailed explanation.

4a. Disclosure of contract suspension/termination, license surrender/revocation/suspension. If Yes, explain:
___ Yes ___ No

4b. Disclosure of pending or threatened litigation. If Yes, explain:
___ Yes ___ No

4c. Disclosure of IRS debt. If Yes, explain and attach proof of good standing with the IRS:
___ Yes ___ No

4d. Related party disclosure. If Yes, explain:
___ Yes ___ No

4e. Has the organization ever filed bankruptcy? If Yes, explain:
___ Yes ___ No

AUTHORIZING SIGNATURES

5. THE APPLICANT CERTIFIES THAT	To the best of my knowledge, information in this response is true and correct, the document has been duly authorized by the governing body of the organization and the organization will comply with the attached assurances should an agreement be signed.	
6. Executive Director	a. NAME - PRINTED	a. SIGNATURE AND DATE
7. Board President	a. NAME - PRINTED	a. SIGNATURE AND DATE

SECTIONS I-VIII -- Selection of Services, Verification of Eligibility for Provision of Services, Staff Qualifications & Requirements, and Organization/Program Information

SECTION I - TYPE OF APPLICATION AND VERIFICATION OF ELIGIBILITY CRITERIA. Check the box by each SERVICE TITLE to indicate if you are applying to provide those services. To be eligible to provide the service, each box must be checked except where indicated otherwise.

SERVICE TITLE: Assessment Provider (Organization)

- Organization is certified by the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS);
- Organization is nationally accredited; and
- All personnel who conduct assessments are licensed professionals (professional counselor, marriage and family therapist, clinical social worker, alcohol and drug counselor) with substance abuse specific training and experience.

If also providing treatment and/or recovery support services, the organization agrees to ensure all participants are informed and encouraged to choose the organization from which they receive treatment and/or recovery support services.

SERVICE TITLE: Outpatient Treatment Provider

- Organization is certified by DMHSAS;
- Organization is nationally accredited;
- Organization has been providing substance abuse treatment services to adults for at least three (3) years; or
- Organization has been providing behavioral health services for at least one (1) year and employs a program director or clinical supervisor who is a licensed alcohol and drug counselor who has at least three (3) years experience providing substance abuse treatment services to adults.

SERVICE TITLE: Intensive Outpatient Treatment Provider

- Same as above with the inclusion of intensive services (which means that for each client, you provide therapeutic services *at least three* (3) hours per day, three (3) days a week, up to fifteen (15) hours per week as indicated by client's need).

SERVICE TITLE: Halfway House Services

SERVICE TITLE: Halfway House Services for Persons with Dependent Children

- Organization is certified by DMHSAS;
- Organization is nationally accredited;
- Organization has been providing substance abuse treatment services to adults for at least three (3) years; or
- Organization has been providing behavioral health services for at least one (1) year and employs a program director or clinical supervisor who is a licensed alcohol and drug counselor who has at least three (3) years experience providing substance abuse treatment services to adults.

SERVICE TITLE: Recovery Support Services Provider (If you check the first box, you do not need to check the other boxes.)

- Organization is certified by DMHSAS and has been providing services to persons with substance abuse issues for at least one (1) year; **OR**
- Organization is in good standing under the requirements of the Oklahoma Secretary of State's Office;
- Organization obtains and maintains documentation of all required occupancy and zoning permits;
- Organization has operational documents that include:
 - the organization's purpose and philosophy;
 - standards of conduct for all personnel and volunteers, including roles, boundaries, supervision, conflict of interest, and training; and
 - client rights and grievance procedures.
- Organization has a governing body (e.g., a board of directors) that meets according to their bylaws to provide fiscal planning and oversight, ensure quality improvement in service delivery, establish policies to guide operations, ensure responsiveness to the community and individuals being served, and delegate operational management to a program manager in order to effectively operate its services;
- Organization uses fiscal management policies, procedures, and practices consistent with generally accepted accounting principles and applicable state and federal laws and regulations;
- Organization has a risk management strategy that includes adequate insurance to cover risks including, but not limited to, liability insurance of no less than one million dollars (\$1,000,000) per incident and three million dollars (\$3,000,000) aggregate Professional Liability Insurance to adequately compensate persons for injury to their person or property occasioned by an act of negligence by the Provider, its agents, employees;
- Organization has at least one year of experience providing the same type of recovery support services to adults in the community.

SECTION II – SERVICES OFFERED: Complete the following by checking the services that the organization/program is qualified and agreeing to provide.		
<p><u>Treatment Services</u> <u>Service Titles</u></p> <p><input type="checkbox"/> Assessment</p> <p><input type="checkbox"/> Outpatient Treatment Services</p> <p><input type="checkbox"/> Intensive Outpatient Treatment Services</p> <p><input type="checkbox"/> Halfway House Services</p> <p><input type="checkbox"/> Halfway House Services for Persons w/Dependent Children</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Recovery Support Services</u></p> <p><input type="checkbox"/> Client Advocacy</p> <p><input type="checkbox"/> Community Recovery Support Services (must be provided by a Credentialed Peer Recovery Support Specialist)</p> <p><input type="checkbox"/> Emergency Food Card</p> <p><input type="checkbox"/> Peer Counseling</p> <p><input type="checkbox"/> Personal Identification</p> <p><input type="checkbox"/> Pre-vocational Services</p> <p><input type="checkbox"/> UA</p> <p><input type="checkbox"/> Education</p> <p><input type="checkbox"/> Training</p> <p><input type="checkbox"/> Other _____</p>	<p><u>Recovery Support Services</u></p> <p><input type="checkbox"/> Referral</p> <p><input type="checkbox"/> Rental Assistance</p> <p><input type="checkbox"/> Socialization</p> <p><input type="checkbox"/> Short-term Emer. Shelter</p> <p><input type="checkbox"/> Spiritual/Faith-based Support</p> <p><input type="checkbox"/> Transportation (agency)</p> <p><input type="checkbox"/> Transportation: Bus Passes (daily, monthly)</p> <p><input type="checkbox"/> Transportation: Fuel Card</p> <p><input type="checkbox"/> Community Outreach</p> <p><input type="checkbox"/> Consultation</p> <p><input type="checkbox"/> Vocational Services</p>
SECTION III – ORGANIZATION (OR PROGRAM) LOCATIONS FOR SERVICES & STAFFING SCHEDULE: For the services that the organization will provide, if services will be provided at locations other than the organization’s central office, and/or if the organization has different Program Names for locations providing services, complete the following information for each program. If a program is providing more than one service, please complete the information for each Service Title. Please make copies of this page as needed.		
Program Name:		Address (Street, city, zip code):
web-site:		
Telephone:	Fax:	
e-mail:		
County:		
Contact Person:	Telephone:	
Title:	e-mail:	
Hours of Operation:	Service Title for which you are qualified and agreeing to provide:	
Schedule of Services:	# of staff providing the Service:	
Average client-to-staff ratio:		
Estimate of # of OATR clients the program can serve:		

SECTION IV – STAFFING QUALIFICATIONS –Identify staff by title and service they will provide and complete the following. You do not need to include each staff member by name, only by the “titles”, i.e. if you have three Care Coordinators, you do not need to name all three Care Coordinators since all three would have the same qualifications, etc.

STAFF TITLE:

SERVICE(S) PROVIDED:

MINIMUM QUALIFICATIONS (education, experience, and/training, etc.):

STAFF TITLE:

SERVICE(S) PROVIDED:

MINIMUM QUALIFICATIONS (education, experience, and/training, etc.):

STAFF TITLE:

SERVICE(S) PROVIDED:

MINIMUM QUALIFICATIONS (education, experience, and/training, etc.):

STAFF TITLE:

SERVICE(S) PROVIDED:

MINIMUM QUALIFICATIONS (education, experience, and/training, etc.):

STAFF TITLE:

SERVICE(S) PROVIDED:

MINIMUM QUALIFICATIONS (education, experience, and/training, etc.):

SECTION V – STAFFING QUALIFICATIONS –CONTINUED

Background Checks: Describe the organization’s process for criminal background checks of all staff and volunteers who have any contact with clients, how results are reviewed, and the criteria for prohibiting employment/volunteerism.

Client Confidentiality Training: Describe the type and frequency of training for staff regarding confidentiality of persons receiving substance abuse treatment and/or recovery support services and records.

SECTION VI- ORGANIZATION/PROGRAM PROFILE:
Describe the organization's history/experience providing services for adults with substance abuse problems. If you have worked with those involved with the criminal justice system, include information regarding that experience also.
Which setting best describes the location where services are provided? (check only one)
<input type="checkbox"/> Community-based program <input type="checkbox"/> Treatment site <input type="checkbox"/> Private office <input type="checkbox"/> Church site <input type="checkbox"/> Government office <input type="checkbox"/> Activity center <input type="checkbox"/> Other:
Gender-specific services (check only one)
<input type="checkbox"/> Serve females only <input type="checkbox"/> Serve males only <input type="checkbox"/> Serve both males and females
Specific culture targeted?
<input type="checkbox"/> Yes (Specify): <input type="checkbox"/> No
Languages (check all that apply)
<input type="checkbox"/> English only <input type="checkbox"/> Spanish only <input type="checkbox"/> Both English and Spanish <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other languages:

SECTION VII – ASSESSMENT PROVIDER APPLICANTS ONLY

All licensed professionals completing assessments are trained in using the Addiction Severity Index and the ASAM PPC-2R.

_____ # of licensed professionals trained in completion of the Addiction Severity Index and ASAM PPC-2R do you currently employed.

Where Will Assessments Be Conducted?

- Staff will travel to other locations to assess clients as needed;
- Staff will only conduct assessments at the organization’s location; or
- Staff will do both of the above.
- Location of assessments will provide privacy and confidentiality for clients.

SECTION VIII – INFORMATION SYSTEM REQUIREMENTS

Does the organization meet the workstation requirements described below?

_____ Yes _____ No

If no, check the categories that are needed to meet the requirements.

Category	Required
<input type="checkbox"/> Operating system version	Windows XP Pro or Home Edition—no VISTA
<input type="checkbox"/> Computer processor	450Mhz or higher
<input type="checkbox"/> Memory	256MB or higher
<input type="checkbox"/> Browser version	Internet Explorer 6.0 or higher, with current service packs; version 7 not recommended, but will work
<input type="checkbox"/> Virus protection	Required. Virus definitions must be kept current.
<input type="checkbox"/> Monitor	Capable screen resolution of 1024x768
<input type="checkbox"/> Printer	Required for printing reports.
<input type="checkbox"/> E-mail	Internet e-mail address
<input type="checkbox"/> Bandwidth	Fastest network connection available and economical to you. Recommend DSL or cable modem.

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SECTION IX – PROGRAM ADDRESS(ES): Location(s) where services will be provided. If more than one location, please complete information for each site. You may copy this page as needed for additional programs	
Program Name:	Address (Street, city, zip code):
Name of contact person:	County:
Telephone: Fax:	Services provided at this location:
e-mail address:	
Program Name:	Address (Street, city, zip code):
Name of contact person:	County:
Telephone: Fax:	Services provided at this location:
e-mail address:	
Program Name:	Address (Street, city, zip code):
Name of contact person:	County:
Telephone: Fax:	Services provided at this location:
e-mail address:	
Program Name:	Address (Street, city, zip code):
Name of contact person:	County:
Telephone: Fax:	Services provided at this location:
e-mail address:	