New York State
Office of Mental Health

Comprehensive Application for Prior Approval Review

14 NYCRR 551

Instructions

Who Must Complete This Application Form

This application should be used for all comprehensive projects subject to prior approval by the Office of Mental Health in accordance with Part 551 of 14 New York Codes, Rules and Regulations (NYCRR), including outpatient, inpatient, and residential programs. For
further reference, consult Part 551 of the regulations.

Providers subject to licensure under Article 28 of the Public Health Law who propose projects subject to licensure under the Mental Hygiene Law must receive prior approval by the Office of Mental Health. Refer to Section 551.8 (d) of NYCRR. Article 28 providers should consult with Office of Mental Health (OMH) and the Department of Helath (DOH) concerning applicable
procedures prior to submission of this form.

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Where to Send PAR Application

Send 6 copies (including an original) to:
Office of Mental Health
Bureau of Inspection and Certification
Att: PAR Unit
44 Holland Avenue
Albany, NY 12229

Discard this page before submitting application

Comprehensive Application for Prior Approval Review

Instructions

Application Form

The PAR application consists of two parts:
Part I (Project Approval) describes the scope of the project for which OMH approval is requested under Part 551. Most of the standards specified in Section 551.7 of the regulations will be applied in reviewing Part I.

Part II (Physical Plant) describes the physical facility in which the program will operate.

An applicant may submit both Part I and Part II for review, or submit Part I only for review and decision, prior to locating a site for the project and submitting Part II. However, final approval of the overall project is contingent upon approval of both Part I and Part II of the PAR application.

Please Note: Prior to submission, a consultation with the local OMH field office is required.

Core Application

All applicants complete Part I, Sections A–D. Complete only those Items within each Section that are relevant to the project. Indicate "not applicable" to Items as appropriate.

Project - Specific Information

Page	Type of Project	Complete these Sections
2	Establishment of a new program by a new provider	E, F, G, H, I, J; Part II
2	Establishment of a new inpatient program	E, F, G, H, I, J; Part II
3	Expand or reduce existing inpatient program by greater than 15% or greater than 10 beds	E, F, G, H, I, K; Part II
3	Close inpatient program	L (3)
3	Change sponsor of Licensed program to a new sponsor	E, F, G, H, I, L (1); Part II
3	Capital projects that are part of a comprehensive PAR or projects that exceed $600,000	H, L (2); Part II
4	Other projects	C (6)

Discard this page before submitting application

Comprehensive Application for Prior Approval Review
14 NYCRR 551

OMH Use Only	
Application No.	**Date Received**

Part I – Project Approval

Section A – Acknowledgment

I certify that all information included and/or attached to this application is accurate and true to the best of my knowledge. I certify my awareness of the requirement for approval by the Office of Mental Health prior to initiation of this project. If an operating certificate is required, I will obtain an operating certificate from the Office of Mental Health prior to operating the program and providing services.

Signature of Chief Executive Officer __________ Date __________

Print or Type Name __________ Title __________

Section B – General Information

1. Identification of Applicant

a. Name of Agency __________

b. Address

No. & Street __________

City, State, Zip Code __________

County __________

c. Agency Legal Name *(if different from above)* __________

d. Phone Number of Applicant __________

e. Medicaid Provider Number *(if any)* __________

f. National Provider ID *(if any)* __________

g. Fax Number of Applicant __________

h. Email Address of Applicant __________

2. Identification of Contact Person

a. Name and Title of Person to Contact for Additional Information __________

b. Address of Contact Person __________

c. Phone Number of Contact Person __________

d. Fax Number of Contact __________

e. Email of Contact Person __________

3. Type of Applicant

- ☐ **Public (check appropriate box below)**
  - ☐ State
  - ☐ County
  - ☐ Municipal
- ☐ **Proprietary (check appropriate box below)**
  - ☐ Individual
  - ☐ Partnership
  - ☐ Corporation
  - ☐ Limited Liability Company
- ☐ **Not-For-Profit Corporation**
- ☐ **Other *(specify)*** __________

4. Type of Facility Operated by Applicant
(Check all that apply)

- ☐ General Hospital (Article 28 PHL)
- ☐ Diagnostic Treatment Center (Article 28 PHL)
- ☐ Psychiatric Center (State-operated)
- ☐ Hospital for the Mentally Ill (Article 31 MHL)
- ☐ Treatment Facility for Children and Youth
- ☐ Other *(specify)* __________

Section B – General Information (Continued)

5. Applicant Experience *(check all that apply)*

☐ Applicant currently provides mental health services licensed by OMH for at least 6 months in all counties applicable to this project.

☐ Applicant currently provides mental health services licensed by OMH for at least 6 months in other counties not applicable to this project.
List Counties: ______________________

☐ Applicant currently provides mental health services licensed by OMH for less than 6 months.
List Counties: ______________________

☐ Applicant currently provides mental health services authorized (but not licensed) by OMH.
List Counties: ______________________

☐ Applicant currently provides mental health services in a State other than New York State.
List States: ______________________

☐ Applicant does not currently provide mental health services.

6. Network Affiliations *(if applicable)*

Identify any networks, in which applicant participates.

7. Affiliated Organizations *(if applicable)*

Identify Affiliated Organization:

Section C – Project Description

(Check all that apply)

1. Establish New Program by a new provider or establishment of a new inpatient program

a. Outpatient *

☐ Clinic Treatment
☐ Continuing Day Treatment
☐ Partial Hospitalization
☐ Intensive Psychiatric Rehabilitative Treatment
☐ Day Treatment for Children/Adolescents
☐ Comprehensive Psychiatric Emergency Program

**For ACT and PROS programs, use specific OMH applications.*

b. Inpatient

☐ Psychiatric Unit in General Hospital
☐ Hospital for Mentally Ill
☐ Residential Treatment Facility for Children and Youth

c. Licensed Housing - Children & Adolescents

☐ Community Residence
☐ Teaching Family Home
☐ Crisis Residence

d. Licensed Housing - Adults Program

☐ Support
☐ Treatment

Site

☐ Congregate
☐ Apartment
☐ Service enriched single room occupancy

e. Crisis Residence - Adults

☐ Crisis Residence

Proposed Capacity	**Proposed Age Range**	**Proposed Name of Program** *(if known)*

Operating Days and Hours of Program

____

Counties to be served by Proposed Program

____

Address of Proposed Program *(if known)*

____

2. Expand or reduce existing *Inpatient* Program by greater than 15% or greater than 10 beds.

Name of Program	Operating Certificate No.	Expiration Date

Address

Current Capacity	Proposed Capacity

Counties to be Served by Expanded Program

3. Close *Inpatient Program*

Number of Recipients Affected by Closure	Operating Certificate No.

Address

Counties Served	Proposed Date of Closure

4. Change of Sponsor of a Licensed Program to a New Sponsor not currently licensed by OMH

Type of Program: ☐ **Outpatient** ☐ **Inpatient** ☐ **Licensed Housing**

Current Sponsor	Counties to be Served by Program(s)
Name of Program(s)	**Current Sponsor Program Operating Certificate No.**

5. Capital Projects that are part of a comprehensive PAR or exceeds $600,000

Construction Type of Program:
- ☐ Substantial Renovation
- ☐ Alteration
- ☐ Acquisition
  - ☐ Purchase of building
  - ☐ Purchase of land
  - ☐ Lease of building
  - ☐ Lease of land
  - ☐ Lease of space only

Type of Program:
- ☐ Outpatient
- ☐ Inpatient
- ☐ Licensed Housing
- ☐ Other *(Specify)* ______

Estimated Cost:

☐ Indicate if state-aid for capital construction is requested *(non-state providers only)*

Estimated Replacement Cost:

$ ______
(substantial renovation project only)

6. Other Projects - Please describe:

Section D – Prior Consultation

1. Confirm consultation meeting with representatives of each local governmental unit (county) served by the project. Refer to 551.5 (c).

County Name	Date of Consult	Name of Applicant Participant	Name of LGU Participant

2. Confirm consultation meeting with representatives of OMH Field Office. Refer to 551.5 (d).

Field Office	Date of Consult	Name of Applicant Participant	Name of OMH Participant

Section E – Program Information

1. Caseload* *(For Outpatient Programs Only)*

a. Program Type ____________________

b. Proposed Annual Caseload ____________________

c. Current Annual Caseload (12 month period) ____________________

Caseload means the total number of unduplicated persons actively served by an outpatient program, based on the previous 12-month period.

2. Services Checklist *(Check all services provided by the program)*

a. Outpatient Programs

Program	Required Services	Optional Services	Additional Services or Services by Other Providers *(specify provider and service)*
Clinic Treatment	☐ initial assessment ☐ psychiatric assessment ☐ psychotherapy-individual ☐ psychotherapy- family/collateral ☐ psychotherapy- group ☐ psychotropic medication treatment ☐ injectable psychotropic medication administration- (for clinics serving adults) ☐ crisis intervention ☐ complex care management ☐ outreach	☐ developmental testing ☐ psychological testing ☐ psychiatric consultation ☐ health physicals ☐ health monitoring ☐ injectable psychotropic medication administration- (for clinics serving only children)	

Program	Required Services	Optional Services	Additional Services or Services by Other Providers *(specify provider and service)*
Continuing Day Treatment	☐ assessment and treatment planning ☐ health screening and referral ☐ discharge planning ☐ case management ☐ medication therapy ☐ medication education ☐ symptom management ☐ psychiatric rehabilitative readiness determination and referral ☐ rehabilitative readiness development	☐ supportive skills training ☐ activity therapy ☐ verbal therapy ☐ crisis intervention ☐ clinical support	☐ case management ☐ crisis intervention ☐ health screening and referral ☐ psychiatric rehabilitative readiness determination and referral
Partial Hospitalization	☐ assessment and treatment planning ☐ health screening and referral ☐ symptom management ☐ medication therapy ☐ medication education ☐ verbal therapy ☐ case management ☐ psychiatric rehabilitative readiness determination and referral ☐ crisis intervention ☐ activity therapy ☐ discharge planning ☐ clinical support		☐ case management ☐ crisis intervention ☐ health screening and referral ☐ psychiatric rehabilitative readiness determination and referral
Intensive Psychiatric Rehabilitative Treatment	☐ psychiatric rehabilitative readiness determination ☐ psychiatric rehabilitative goal setting ☐ psychiatric rehabilitative function and resource assessment ☐ psychiatric rehabilitative service planning ☐ psychiatric rehabilitative skills and resource development ☐ discharge planning		
Day Treatment	☐ health screening and referral ☐ medication therapy ☐ verbal therapy ☐ crisis intervention ☐ case management ☐ social training ☐ task & skill training ☐ socialization		☐ social training ☐ task & skill training ☐ socialization
CPEP	☐ crisis intervention ☐ crisis outreach ☐ crisis residence ☐ extended observation beds ☐ triage & referral ☐ Other (specify) ______________		

b. Licensed Housing: New Sponsor not selected through the OMH Request for Proposal (RFP) process		
Program	**Required Services**	**Additional Services or Services by Other Providers** *(specify provider and service)*
Adults	☐ assertiveness/self advocacy ☐ community integration/resource development ☐ daily living skills ☐ health services ☐ medication management & training ☐ parent training ☐ rehabilitation counseling ☐ skill development services ☐ socialization ☐ substance abuse services ☐ symptom management ☐ Other (specify) ________________________	
Children & Adolescents	☐ behavior management ☐ case management ☐ counseling ☐ daily living skills ☐ education/vocation support ☐ family support ☐ health services ☐ independent living skills ☐ medication management ☐ medication monitoring ☐ respite ☐ room & board ☐ socialization ☐ crisis stabilization	

C. Inpatient Programs - List Services

Section F – Staffing

1. Outpatient Staffing Chart Full Time Employee (FTE)

List Each Position by Title	Number of FTE's	Days Worked (i.e. M-F)	Hours or Shift Worked (i.e. 7-3 or Eve)	Estimate Annual Salary Cost in Whole Dollars
Ex: Registered Nurse	*2.0*	*M-F*	*8-5*	*85,000*
Ex: MSW	*0.5*	*M, W, F*	*1-7*	*25,000*
Ex: Psychiatrist	*0.4*	*T & W*	*9-5*	*30,000*
Totals				

2. Indicate the standard workweek (in hours) of a full-time staff position.

3. Describe how staff supervision will be provided.

4. Inpatient Staffing - provide staffing plan that shows staff coverage 24/7.

Section G – Financial

1. Operating Budget
(attach additional pages as needed) Fiscal Year: ______________Jan - Dec ______________July-June

Clinic programs must complete the Clinic Projection Tools found on the OMH website.

OPERATING EXPENSES	For Inpatient Expansions Provide An Incremental Budget	Operation During First Full Fiscal Year	Operation During Second Full Fiscal Year
Staffing Salaries			
Staff Fringe Benefits			
Rent or Mortgage			
Equipment			
Utilities			
Insurance			
Travel			
Food			
Office Supplies			
Housekeeping			
Program Supplies			
Debt Service (other than Mortgage)			
Administration and Overhead *(Complete G4d)*			
TOTALS:			
OPERATING INCOME			
Patient Fees			
Medicaid Base Revenue			
Medicaid Managed Care			
Medicare			
Third Party Payments			
Direct State Expenditures (State Program)			
Grants *(specify source)*			
Contributions or Other Revenue *(specify each type, such as: from individual, other groups, etc.)*			
GOVERNMENT SUPPORT			
State Aid			
Other Government Income *(specify each funding source)*			
TOTALS:			

2. Expected Utilization for Outpatient Programs:

	1st Full Year	2nd Full Year
Annual Medicaid Visits		
Individual Visits		
Group Visits		
All Non-Medicaid Annual Visits		
Individual Visits		
Group Visits		
Total Annual Visits		
Individual Visits		
Group Visits		
Caseload*		
Program Capacity**		

**Caseload means the proposed average number of persons to be served by an outpatient program per month.*
***Capacity is defined, for outpatient, as the number of recipients who can be served on site at a given time.*

Service Frequency

a. For Outpatient Programs, what percentages of patients are expected to attend the program?

Once a week or less   2 or 3 times a week   4 or more times a week

b. For Continuing Day Treatment, Partial Hospitalization, and Day Treatment Programs, what percentage of visits are projected to be 5 or more hours in duration? ______________%

3. Expected Utilization for Residential and Inpatient Programs:

	1st Full Year	2nd Full Year
Total resident/patient days		
Total Medicaid days		
Caseload (annual)		
Program Capacity**		
Average length of stay		
Average Occupancy		

*Capacity** is the total number of beds to be listed on the operating certificate.*

4. Budget Information

a. Explain the methodology used to derive revenue by payor source and the projected utilization upon which the budget is based. Include data pertaining to caseload, visits, maximum capacity, frequency, seasonal fluctuation, etc. *(Attach separate sheet, if necessary.)*

b. If construction/renovation is involved in this application, describe its anticipated effect on the cost per unit of care. *(Attach separate sheet, if necessary.)*

c. Describe program development costs (i.e., costs prior to program operation) and financing.
(Attach separate sheet, if necessary.)

d. Describe how administrative and overhead costs were determined and provide a breakdown of costs on a separate sheet.

e. For new outpatient programs, other than clinics, indicating fee-for-service Medicaid, identify the specific source for the State share of Medicaid and submit the award letter from the LGU, if applicable.

f. Submit the last three (3) years of financial statements prepared by a certified public accountant. (Not applicable to applicants who are state, county, or municipal agencies).

Section H – Disclosures

1. Do any members of the existing/proposed board of directors of the corporation, officers, stockholders, or executive staff have a real property interest in the land, building, or equipment used by the programs?
◯Yes ◯No
If YES, identify the individual, his/her address, his/her relationship to the program, and fully describe the nature of the interest in an attachment.

2. Do any relatives of the members of the existing/proposed board of directors of the corporation, officers, stockholders, or executive staff have a real property interest in the land, building, or equipment used by the program? ◯Yes ◯No

If YES, identify the individual, his/her address, his/her relationship to the program, and fully describe the nature of the interest in an attachment.

3. Do any other partnerships or corporations which include members of the existing/proposed board of directors of the corporation, officers, stockholders, or executive staff have a real property interest in the land, building, or equipment used by the program? ◯Yes ◯No

If YES, identify the individual, his/her address, his/her relationship to the program, and fully describe the nature of the interest in an attachment.

4. Will management, clinical services, or administrative functions of the program be provided by individuals who are not employees of the applicant or by organizations other than the applicant?
◯Yes ◯No
If YES, identify the individual or organization, and provide reasons for entering into the proposed contract, background on the principals, officers and directors of the organization, including information in sufficient detail to enable review of the project pursuant to 551.7(a)(14) in an attachment and include a copy of the contract.

Section I – Attachments for Ownership, Character, and Competence

1. For each incorporator, member of the board of directors, stockholder, partner, or individual owner, provide the requested information on the Section I, Attachment "Ownership Information".

2. New providers must submit the following document(s) where applicable:

a. Check items submitted:

- ☐ Certificate of Incorporation
- ☐ Certificate of Amendment of the Certificate of Incorporation
- ☐ Partnership Agreement
- ☐ Limited Liability Company Articles of Organization and Operating Agreement
- ☐ Sole Proprietor - Provide Administrative & Organizational Information

b. Submit the following:

- ☐ List all mental health programs or services and any other human services programs or services operated or managed by your organization during the last 10 years. List the names, addresses, license numbers and state regulatory agency having jurisdiction for each.
- ☐ Provide any additional information substantiating the character, competence, and standing of the applicant for the type of project proposed in this application.

Section J – Attachments for Establishing a New Provider or a New Inpatient Program

1. Service Area

a. Define the geographic or political boundaries of the area to be served by the proposed program.
b. Describe how the proposed program will function within the mental health system in the area to be served.

2. Need

a. Explain why the program is needed.
b. Describe the target population for the program qualitatively and quantitatively, specify gender, age and ethnicity. Describe the service needs of the target population and their families, and indicate how the proposed program will address these needs.
c. Describe how your organization or your program currently serves the target population (if applicable).
d. Provide any other information supporting need for the proposed program.

3. Access

a. Describe how the program will serve the poor and the medically indigent.
b. Describe the mechanisms by which the program will address the cultural and ethnic characteristics in the treatment of the population in the service area.
c. Describe any factors limiting admission, i.e. fiscal, diagnostic or geographic.
d. Describe the mechanisms for participation of consumer representation within the governing body (if applicable).
e. Describe plans to enable persons with physical disabilities to access services, consistent with the characteristics of the population to be served.
f. Indicate the transportation arrangements through which individuals will access the program.

4. Continuity of Care

a. Provide a plan to ensure continuity of care within the mental health system and with other service systems. Identify specific providers to ensure linkages among programs.
b. For outpatient programs, describe a plan by which patients in the program will be assisted during hours when the program is not in operation.

5. Implementation

Describe start-up or phase-in activities necessary to implement the program. Include time frames in your description.

6. Functional Program

- **a. Mission -** Provide an overview of the proposed program and describe the treatment philosophy.
- **b. Organization -** Describe the lines of authority from the governing body to the proposed program. Indicate the relationship of the program to other programs operated by your agency.
- **c. Goals and Objectives -** Describe the goals, objectives, and expected outcomes of the program. Indicate average length of stay.
- **d. Admission -** Describe admission criteria, policies, and procedures. Include inclusionary and exclusionary criteria, process, timeframes, record-keeping, and procedures for notifying families and programs in which recipients are currently admitted.
- **e. Discharge -** Describe discharge criteria, policies, and procedures. Include process, time frames, record-keeping, and procedures for notifying families and programs to which recipients will be referred for further services.
- **f. Services -** Provide a detailed description of all services available to recipients admitted to the program. Specify how these services will be provided and the staff position responsible for providing the service. Identify the provider of any services to be delivered by other than the proposed program. For programs serving children, describe plans to coordinate with the family and the school.
- **g. Staffing -** Include the qualifications and duties for each staff position. Provide a rationale for the proposed staffing plan.
- **h. Quality Assurance/Improvement -** Describe your plans for utilization review, incident management, and internal monitoring.
- **i. Premises -** Provide a description of the premises to be used by the program. Include appropriately labeled sketch drawings showing use and dimensions of rooms.
- **j. Waivers -** Identity any waiver requests and provide justification for the request. Describe the effect on your proposed program if the request is denied.

Section K – Attachments for Inpatient Program Expansion or Reduction of an Existing Program by Greater than 15% or Greater Than 10 Beds

1. Provide justification and data supporting the need for the expansion or reduction.

2. Describe the impact of the expansion or reduction on services, staffing, and space, provide incremental staffing.

3. For programs expanding to serve children, describe plans to coordinate with the family and the school.

4. Indicate the fiscal impact of the expansion or reduction. If the program will operate at a deficit, describe how this deficit will be covered. Include all sources of revenue. Provide the incremental changes to expenses and revenues.

Section L – Attachments for Change of Sponsor, Capital Projects, or Other Projects

1. Change of Sponsor of a licensed program to a new sponsor (sponsor that does not have any licensed OMH programs)

- **a.** Identify new sponsor and current sponsor.
- **b.** Describe the reasons for changing sponsorship of the program(s).
- **c.** Include written concurrence from the current sponsor for transfer of the program(s). If current sponsor is a corporation, include resolution from the Board of Directors.
- **d.** Describe any changes to be made in operation of the program(s).
- **e.** Describe the qualifications of the new sponsor to operate mental health programs.
- **f.** Indicate any financial considerations involved in the change of sponsor.
- **g.** Submit a transition plan, including time frames, for the change of sponsor.

2. Capital Projects that are part of a Comprehensive PAR or projects that exceed $600,000.

a. Describe the reasons for the project and any impact upon mental health programs.
b. Complete Part II of the application.

3. Closure of an Inpatient Program

a. Indicate proposed effective date of closure.
b. Describe the reasons for closing the program.
c. Submit a transition plan showing that recipients will be linked to appropriate alternative programs, which have agreed to accept the referrals; recipient transportation needs will be addressed; and follow-up will occur to confirm recipient linkage to programs.
d. If the rationale for closure includes fiscal considerations, provide documentation to substantiate the lack of fiscal viability in the long term.
e. Submit the plan for safeguarding recipient records and financial accounts.
f. Describe the process and timeframe for evaluation and placement of recipients and completion of other activities to conclude the affairs of the program.
g. Provide the Resolution of the Board of Directors authorizing the closure.

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Part II – Physical Plant

Section A – Facility Description

1. Identification of Applicant

a. Applicant's Name

b. Applicant's Address

No. & Street

City, State, Zip Code

2. Type of Project *(check all that apply)*

Facility	Program	
☐ Outpatient	☐ Clinic ☐ CDT ☐ PH	☐ IPRT ☐ Day Treatment ☐ CPEP
☐ Inpatient	☐ General Hospital Unit ☐ Psychiatric Hospital ☐ RTF	
☐ Licensed Housing * − Adults	☐ Treatment ☐ Supportive	☐ Congregate ☐ Apartment ☐ SRO
☐ Licensed Housing * − Children & Adolescents	☐ CR ☐ Family Based Treatment	☐ Teaching Family Home ☐ Crisis Residence
☐ Crisis Residence * − Adults		

**For projects not selected through the RFP process*

3. Property Information

a. Address of Proposed Premises

b. Owner of Premises

Name

No & Street

City, State, Zip Code

c. Approximate Size of Property

__________ Sq. Ft.

d. Building Size:

1. Number of Floors:
2. Total Sq. Ft. in Building: Sq. Ft.
3. Identify Floors to be Used:
4. Amount of Space to be Used: Sq. Ft.

4. Zoning and Permitted Uses:

a. Is proposed use acceptable under current zoning?

◯ Yes ◯ No

b. If not, has change, variance or waiver been requested? *(If received, attach documentation.)*

◯ Yes ◯ No

5. Description of Neighborhood:

6. For Leased Property:

a. Term of Lease Agreement: ____________

Effective Date of Lease: ____________

b. Is Lease Renewable:

◯ Yes ◯ No

c. Annual cost per Sq. Ft.

$ ____________

d. Estimated Total Rental Cost per Year:

$ ____________

e. Estimated Applicant's Cost for Capital Improvement $ ____________

f. Applicant's Method of Financing Capital Costs:

☐ **Included in Lease Agreement**
☐ **Applicant's Cash Investment**
☐ **Other** *(specify)* ____________

g. Attach Copy of Proposed Lease

Section B – Capital Project

1. Type of Capital Project

☐ Acquisition
☐ Construction
☐ Substantial Renovation
☐ Alteration

3. State Aided Project

☐ Project financing will include request for an OMH capital grant pursuant to Article 41 of the Mental Hygiene Law.

☐ Indicate if a Capital Construction Project Justification Form has been submitted to the OMH Field Office.

2. Proposed Project Timetable
(complete applicable sub-sections)

	MONTH/YEAR
a. Preliminary Architectural Drawings	________
b. Final Architectural Drawings/Specifications	________
c. Bidding Documents	________
d. Bidding of Project	________
e. Awarding of Contracts	________
f. Commencement of Construction/Renovation	________
g. Completion of Construction/Renovation	________
h. Commencement of Program Operation	________

Section C – Attachments

1. Projects for construction or substantial renovation, must provide the following:

a. Architectural plans prepared by registered architect or professional engineer.
b. Analysis as to compliance with appropriate building and safety codes.
c. Proposed use of space showing sufficient and appropriate space to support requested program, capacity & utilization.
d. For inpatient projects, submission of hardware specifications.

2. Projects for Alteration:

a. Description of the scope of alterations.
b. Architectural plans prepared by registered architect or professional engineer showing the room arrangement with the utilization of each room and space.
c. Analysis of proposed premises as to compliance with appropriate building and life safety codes. If applicable, submission of hardware specifications.

3. Projects for Acquisition of property valued at greater than $600,000.

a. Proposed contract of sale.
b. Proposed use of space showing sufficient and appropriate space to support requested use, including program, capacity, and utilization.
c. Analysis as to compliance with appropriate building and safety codes.

4. Projects for Licensed Housing not selected through the OMH RFP process.

- **a.** For programs proposed to house 4 to 14 residents, indicate whether the site selection process has been initiated pursuant to Section 41.34 of the Mental Hygiene Law.
- **b.** Submit the architectural feasibility study for the property if not previously submitted. The feasibility study maybe submitted for review prior to initiation of the site selection process.
- **c.** Submit requests for any waivers pursuant to 14 NYCRR 551.11.

Section D – Additional Requirements Prior to Final Approval

1. Submit a written statement from your registered architect or professional engineer upon completion of the capital project indicating that all work has been completed in compliance with appropriate codes and in accordance with plans approved by the Office of Mental Health.

2. Submit a Certificate of Occupancy or equivalent document from the local buildings jurisdiction.

3. Complete a site visit by OMH Field Office staff at the conclusion of the project prior to occupancy of the building or initiation of the program.

Section I - Attachments for Ownership, Character, and Competence

Name:	Home Address:	Business Address:
Occupation:		

Community and philanthropic experience:

Previous association with human service facility within the last 10 years including positions held as employee, owner, or member of the board of directors:

Explanation of conviction for any offense against the law (except traffic charges) and explanation of charges pending in any court:

Name:	Home Address:	Business Address:
Occupation:		

Community and philanthropic experience:

Previous association with human service facility within the last 10 years including positions held as employee, owner, or member of the board of directors:

Explanation of conviction for any offense against the law (except traffic charges) and explanation of charges pending in any court:

Name:	Home Address:	Business Address:
Occupation:		

Community and philanthropic experience:

Previous association with human service facility within the last 10 years including positions held as employee, owner, or member of the board of directors:

Explanation of conviction for any offense against the law (except traffic charges) and explanation of charges pending in any court: