Reset Form Print Form

Application for Prior Approval Review
14 NYCRR 551
Personalized Recovery Oriented Services
PROS Program (Part 512)

Who Must Complete This Application

This application should be used to obtain an initial operating certificate as a PROS program. A PROS program is subject to prior approval review (PAR) by the Office of Mental Health in accordance with Part 551 of 14 NYCRR. For further reference, consult Part 551 of the regulations.

When completing the PAR Application refer to Part 512 - PROS Regulations and the OMH PROS Handbook on the OMH website.

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(c) of 14 NYCRR. Article 28 providers should consult with OMH and DOH concerning applicable procedures prior to submission of this form.

Submit one application for each PROS program proposed. If a single PROS program will operate at multiple sites, only one application should be submitted. If an agency proposes to operate more than one distinct PROS program, a separate application for each PROS program must be submitted.

Contents of the PAR Application

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Where to Send the Application

Send **8** copies (including an original) to:

Bureau of Inspection and Certification
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229
Attn: PAR Unit

An information copy should be sent to the appropriate County and OMH Field Office pursuant to Section 551.8(b).
Note: OMH cannot accept PAR applications sent via fax or e-mail.

Discard this page before submitting application.

Application for Prior Approval Review
14 NYCRR 551
PROS Program: Application for Initial Operating Certificate (Part 512)

OMH Use Only

Application #:	☐ Comprehensive PROS with Clinical Treatment ☐ Comprehensive PROS ☐ Limited License PROS	Date Received:

Part 1 - 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. I will obtain an operating certificate from the Office of Mental Health prior to operating the program and providing services as a PROS program.

The budget submitted with this application indicates my agency's best estimates for expenses. In the event that the estimated revenue falls short of these projections, it is understood that the agency, as the PROS provider, retains responsibility to compensate for any losses that are incurred.

Signature of Chief Executive Officer _____ Date _____

Print or Type Name _____ Title _____ Name of Organization _____

Section B - General Information

1. Identification of Applicant

a. Name of Organization Applying for License:

b. Address

No. & Street:

City, State, Zip Code:

County/Borough:

c. Legal Name of Applicant

d. Phone Number of Applicant

e. Medicaid Provider Number (If any)

f. National Provider Identifier

2. Identification of Contact Person

a. Name of Person to Contact for Additional Information

b. Address of Contact Person

c. Phone Number of Contact Person

d. Fax Number of Contact Person

e. E-mail Address of Contact Person

3. Identification of *Fiscal* Contact Person

a. Name of Fiscal Contact Person
(if different from "2" above)

b. Phone Number of Fiscal Contact Person

c. Fax Number of Contact Person

d. E-mail Address of Fiscal Contact Person

Section B - General Information (continued)

4. Type of Applicant

Public
- ☐ State
- ☐ County
- ☐ Municipal

Proprietary
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Not for Profit Corporation
- ☐ Other (specify) _____

5. Type of Facility Operated by Applicant (Check all that apply)
- ☐ General Hospital (Article 28 PHL)
- ☐ Diagnostic and Treatment Center (Article 28 PHL)
- ☐ Psychiatric Center (state-operated)
- ☐ Hospital for the Mentally Ill
- ☐ Residential Treatment Facility For Children and Youth
- ☐ Outpatient Facility
- ☐ Residential Facility
- ☐ Other (specify) _____

6. Network Affiliation (if applicable)
Identify any networks in which the applicant participates.

7. Affiliated Organizations (if applicable)
- ☐ Applicant is actively controlled by another corporation.
- ☐ Applicant is passively controlled by another corporation.

Identify Controlling Corporation:

Name: _____

Address: _____

Section C - Project Description

1. Type of PROS license requested (choose one):
- ☐ Comprehensive PROS with clinical component
- ☐ Comprehensive PROS
- ☐ Limited License PROS (Intensive Rehabilitation & Ongoing Rehabilitation and Support)
  If checked, complete Item 5 below.

2. Indicate county or counties of individuals to be served by PROS (list primary county first). Indicate the percentage to be served in each county. In New York City, indicate specific county.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section C - Project Description (continued)

3. Will the PROS operate at multiple sites? ☐Yes ☐No

If Yes, provide address and service component(s) for each site below (Refer to Section J, Item #3 of this application:

Primary Site: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

Additional Sites:

Multi-site 1: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

Multi-site 2: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

Multi-site 3: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

Multi-site 4: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

Multi-site 5: ☐ CRS ☐ IR ☐ ORS ☐ Clinical (check appropriate components)

Address: _____

For more sites than allowed above, attach additional sheet.

Primary Site is the location where the majority of PROS services are delivered and is usually where program administrative staff is located.

Multi-site is a location where PROS services will be provided other than the primary site.
CRS = Community Rehabilitation and Support **IR** = Intensive Rehabilitation
ORS = Ongoing Rehabilitation and Support

4. Will the PROS applicant contract with other providers for any PROS services per 512.6(f)?

☐No ☐Yes (If Yes, **Section I and Section J, Item #10** of this application must be completed.)

5. Applicable to Limited License PROS:
Per 512.6(c), a fully-integrated Comprehensive PROS is preferred. A Limited License PROS will be considered where the County identifies need and the capacity of the provider is not sufficient to deliver a Comprehensive PROS. Please provide a detailed rationale for your request for Limited License PROS that addresses need and provider capacity. Attach additional information as necessary to support your request.

Section D - Program Information

1. Proposed Name of PROS Program (if known)

_____

2. Mailing Address of PROS Program (if known)

_____

3. Capacity and Persons Served:

Capacity is the number of individuals, on average, receiving services at a particular location at a given point in time during an average day. The number of recipients served daily is determined by the amount of program space available and the amount of staff available to provide services, and should be consistent with the OMH-approved County Plan.

Indicate capacity for each site proposed:	**Initial Operation**	**Full Operation**	**Example: Initial**	**Example: Full**
Primary Site			100	120
Additional Sites: Multi-site #1			25	25
Multi-site #2			20	30
Multi-site #3				
Multi-site #4				
Multi-site #5				
Total Capacity			**145**	**175**

Persons Served is the total number of individuals receiving services at all sites, on average, by the PROS program for a given month.

Each individual should only be counted once, even if they receive services at more than one location during the month.

The number of persons served monthly should be consistent with the OMH-approved County Plan.

Indicate expected number of persons served:	**Initial Operation**	**Full Operation**	**Example: Initial**	**Example: Full**
Monthly			80	200
Annually				270

4. Persons served by PROS Component:

	Initial Operation	Full Operation
a. Average number of individuals* receiving CRS monthly:	_____	_____
	Initial Operation	Full Operation
Average number of individuals* receiving IR monthly:	_____	_____
	Initial Operation	Full Operation
Average number of individuals* receiving ORS monthly:	_____	_____

*Individuals may be counted more than once when determining the number of individuals served (individuals may not be counted more than once when billing). For example: A single individual can be counted as receiving CRS and again be counted as receiving IR.

****Initial Operation** means during the first three months of operation. **Full Operation** means when the PROS has operated for one year.

Section D - Program Information (continued)

b. If Comprehensive PROS includes clinical services, provide percentage of individuals expected to receive clinical services from the PROS on a **monthly basis:** _____%

Example: A PROS program on average serves 100 individuals per month and 50 of the 100 receive clinical services. The percentage would be 50%.

c. Does the applicant currently operate an OMH licensed clinic in the PROS service area? ☐Yes ☐No

If Yes, identify program(s) and list counties served: _____

d. Identify all expected referral sources.

Section E - Prior Consultation

1. Part 551.5(c) requires applicant to consult with their local county representatives prior to submission of the application. Confirm consultation with representatives of each County served by the project. Refer to 551.5(c).

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

2. Is a **Letter of Support** from the County attached? ☐Yes ☐No

If not, explain why:

3. Part 551.5(d) requires applicant to consult with their OMH field office representatives prior to the submission of application. Confirm consultation 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 F - Staffing

1. Initial Operation - Staffing Chart

Include all program staff employed by the applicant and all contract staff who will be on staff within the first three months of operation. It is expected that core staff will be hired at the point of licensing. Use additional staffing sheets as needed.

Check the number of hours in a standard work week:

☐35 ☐37.5 ☐40 ☐Other: _____hrs

List each position by title. **Examples:** Program Director, Supervising Social Worker, Intake Coordinator, Peer Specialist, Registered Nurse, etc. Indicate whether staff member will perform direct clinical (DC) or programmatic (Prog) functions.	**FTE**	**Days Worked** (M, T, W, Th, F, Sa, Su)	**Total Weekly Hours Worked**	**Indicate the professional status of clinical staff:** **P** = Professional* **PHA** = Licensed Practitioner of the Healing Arts** **P/USP** = USPRA*** **PTR** = Professional/ Transition**** **NP** = Non-Professional	**Indicate if staff are:** **AS =** applicant's staff **or** **CS =** contract staff	**Identify work location(s) for each staff as noted in Section C, Item #3:** **P** = primary **MS** = multi-site	**Identify all PROS Program Component assignments for each staff (CRS, IR, ORS, CL).**	**Annual Salary Cost** (without fringe benefits) Note: **Total** at bottom of page should equal "Staffing Salaries" for Initial Operation on page 10.
Totals								

*** Professional** = an individual who is a creative arts therapist, CASAC, occupational therapist, pastoral counselor, rehabilitation counselor, social worker (Master's degree in social work), or a therapeutic recreation therapist. Other professional disciplines may be included only upon OMH written approval as defined in Part 512.4(z)(18).

**** Licensed Practitioner of the Healing Arts** = a professional who is licensed as a nurse practitioner, physician, physician assistant, psychiatrist, psychologist, registered professional nurse, or a social worker (LCSW/LMSW) as defined in Part 512.4(p).

***** USPRA** = staff credentialed by the United States Psychiatric Rehabilitation Association (512.4(z)(18)).

****** Professional/Transition** = Indicates staff currently employed by the provider who are not professionally credentialed, but are counted as professional staff under Part 512.15(d). (Refer to Section F, item 5. of this application.)

Section F - Staffing (continued)

2. Full Operation - Incremental Staffing Chart

Include all program staff employed by the applicant and all contract staff to be added to the Initial Staffing Chart on Page 6 to bring staffing levels up to full operation. **Please *do not* include staff already listed on the Initial Operation Staffing Chart on Page 6.** Use additional staffing sheets as needed.

List each position by title. Examples: Program Director, Supervising Social Worker, Intake Coordinator, Peer Specialist, Registered Nurse, etc. Indicate whether staff member will perform direct clinical (DC) or programmatic (Prog) functions.	**FTE**	**Days Worked** (M, T, W, Th, F, Sa, Su)	**Total Weekly Hours Worked**	**Indicate the professional status of clinical staff: P** = Professional* **PHA** = Licensed Practitioner of the Healing Arts** **P/USP** = USPRA*** **PTR** = Professional/ Transition**** **NP** = Non-Professional	**Indicate if staff are: AS =** applicant's staff **or CS =** contract staff	**Identify work location(s) for each staff as noted in Section C, Item #3: P** = primary **MS** = multi-site	**Identify all PROS Program Component assignments for each staff (CRS, IR, ORS, CL).**	**Annual Salary Cost** (without fringe benefits)
Totals								

*** Professional** = an individual who is a creative arts therapist, CASAC, occupational therapist, pastoral counselor, rehabilitation counselor, social worker (Master's degree in social work), or a therapeutic recreation therapist. Other professional disciplines may be included only upon OMH written approval as defined in Part 512.4(t).

**** Licensed Practitioner of the Healing Arts** = a professional who is licensed as a nurse practitioner, physician, physician assistant, psychiatrist, psychologist, registered professional nurse, or a social worker (LCSW/LMSW) as defined in Part 512.4(o).

***** USPRA** = staff credentialed by the United States Psychiatric Rehabilitation Association (512.4(t)(14)).

****** Professional/Transition** = Indicates staff currently employed by the provider who are not professionally credentialed, but are counted as professional staff under Part 512.15(d). (Refer to Section F, item 5. of this application.)

Section F - Staffing (continued)

3. Identify any of the positions listed in Section F, item 1. that are students, trainees or volunteers.

4. Describe how staff supervision will be provided. Include titles of supervisors.

5. Do you require approval under Part 512.15(d) for currently employed staff to be counted as professional staff? ☐No ☐Yes

If yes:

a. Identify staff by name, current title and proposed title:

Staff Name	**Current Title**	**Proposed Title, if different from current.**

b. Describe the program's transition plan to comply with the professional staff requirements set under Part 512.7(d)(2) of the PROS regulations. Please note that any professional staff waivers will be time-limited.

Section G - Financial

1. Operating Budget Based on Local Fiscal Year: ☐Jan - Dec ☐July - June

Operating Expenses **Check one:** ☐Accrual Basis ☐Cash Basis	**Phase-In Period** (First three months of operation)	**Full Annual Operation** (12 months)
Staffing Salaries		
Staff Fringe Benefits		
Rent or Mortgage		
Equipment		
Utilities		
Insurance		
Travel		
Food		
Office Supplies		
Housekeeping		
Program Supplies		
Debt Service (Other than Mortgage)		
Administration Costs (Provide all administrative and support staff titles and salaries on a separate sheet)		
Training		
Computers		
Other Expenses (specify)		
Expense Totals:	0	0

Section G - Financial

Operating Revenue **Check one:** ☐Accrual Basis ☐Cash Basis	**Phase-In Period** (First three months of operation)	**Full Annual Operation** (12 months)
Medicaid		
Medicare		
Third Party Payments		
Recipient Fees		
Federal Grants (specify)		
Contributions (specify each type such as: from individual, other groups, etc.)		
Government Support (specify each funding source)		
Surplus from another PROS site within the agency to cover deficit. Identify the PROS program to which surplus funds are attributed:		
Other Revenue:		
Non-GAAP adjustment (Represent as a negative value)		
Revenue Totals:		

Accrual Basis: Budget is based on when services are provided (revenue) or when costs are incurred (expenses).
Cash Basis: Budget is based on when program received payment for services provided (revenue) or when goods and services are paid (expenses).

2. Attach the Model Sheet which was completed as part of the PROS fiscal tool for Full Operation. NOTE: All utilization and revenue projections on the Model Sheet MUST match those submitted in the PAR application.

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

Section G - Financial (continued)

4. If program budget indicates a deficit, provide detailed plan to address the deficit and maintain financial viability of the program. (Attach a separate sheet if necessary)

5. If the program anticipates receiving VESID funding, identify the amount budgeted and explain how this amount was determined.

Section H - Ownership, Character, and Competence

1. If the applicant *Does Not* currently operate any OMH licensed outpatient programs: Prior to OMH licensure of a program, the license holder must have the authority to operate outpatient mental health programs under its organizational structure. New applicants will need to include or add language to their organizational document that authorizes operation of outpatient mental health programs. OMH approval is requested for one of the following documents (check as indicated):

- ☐ Certificate of Incorporation
- ☐ Certificate of Amendment of the Certificate of Incorporation
- ☐ Partnership Agreement
- ☐ Limited Liability Company Articles of Organization and Operating Agreement
- ☐ Other (specify): _____

Please include a copy of the document checked above.

NOTE: For purposes of licensure, **"outpatient"** includes a broad class of facilities and programs providing mental health services other than inpatient and residential. "Outpatient" includes PROS programs as well as programs licensed pursuant to Part 587 of 14 NYCRR.

Section I - Disclosure

1. Will any PROS components or services be provided by an organization other than the applicant through a management services contract or a clinical services contract? ☐ Yes ☐ No

If yes, indicate as appropriate:

☐ The following information is attached for each contract:

- Name of organization
- Mailing address of organization
- The PROS component or PROS services provided by the organization
- Address(es) where the PROS component or PROS services will be provided
- Reasons for entering into the proposed contract with the primary provider
- Copy of the proposed contract
- Information required under Section H , items 1-4 of this application (Ownership, Character, and Competence)
- Information required under Section I , items 1-3 of this application (Disclosure)

☐ Information is provided pursuant to Section J, item 10 of this application.

Section J - Attachments

1. Functional PROS Program Description

a. Overview - Provide an overview of the proposed program.

b. Goals - Describe the core goals of your PROS program and indicate how you expect to achieve these goals.

c. Organization - Describe the lines of authority from the governing body to the PROS program or include an organization chart. Indicate the relationship of the program to other programs operated by your agency.

d. Admission - Describe admission criteria and process for admission, including expected timeframes for admission decisions and procedures for notifying programs in which recipients are currently enrolled.

e. Discharge - Describe criteria and process for transition from the PROS, including procedures for notifying programs to which recipients will be referred for further services.

f. Services - Describe how PROS services (listed in Appendix A or B) will be provided by staff of the PROS program. Include on-site and off-site services. Provide a brief description of a typical day within the PROS program. Note: If Cognitive Remediation Therapy (CRT) will be offered, specify how and by whom the service will be rendered. Explain how staff will be trained to provide CRT.

g. Program Schedule - Describe how the weekly or monthly program schedule will be developed and updated.

h. Staff Communication - Describe plan to assure clinical supervision and other mechanisms for staff communication.

i. Quality Management - Describe plans for utilization review and incident management within the PROS program.

j. Case Records - Describe content for case records, individualized recovery plans (including provision for CRS, IR, ORS and clinical treatment), assessments, case reviews, and progress notes. Provide specific assessment tools, IRP and other documentation to be used. Describe how information gathered from such tools will be translated into goals. In addition, describe how the program will maintain documentation to support, for each individual, the duration of program participation time per day, types and numbers of PROS services provided per day, and the number of PROS units accrued per day and per month.

k. Recipient Participation - Describe how program participants will be included in decision-making processes. Include how they will be involved in their case record documentation process.

Section J - Attachments (continued)

2. Staff Competency

a. Describe how the program will ensure appropriately competent staff are providing services in all PROS components.
b. Describe plans to provide staff training and supervision, including initial training and orientation, and on-going training and development, to maintain and improve staff competence.
c. If applicable, describe plans to phase-in staff positions listed in Section F of this application. Include timeframes.
d. Describe how the program defines the performance expectations (competencies) for all staff positions.
e. Describe how the program will assess each staff member's ability to meet the performance expectations (competencies) stated in the job description.
f. Describe plans to train staff in cultural competence, awareness and sensitivity, and to provide culturally relevant services. Training and technical support, including assessment tools, are available.

3. Integration of PROS Components

a. Describe how components will coordinate and integrate services within the PROS program. Describe how the IRP will be utilized in this process. If applicable, describe the plan to integrate the clinic component into the rehabilitation and support services of PROS.
b. If PROS components will operate at multiple sites, describe:
   i. proximity of sites; distance and travel time
   ii. plan to assure recipient access to sites
   iii. plan for management and clinical supervision across multiple sites
   iv. the staffing plan for each component at each site
   v. how recipient information will be shared among sites to assure continuity of care and confidentiality.
   vi. if multiple sites incorporate multiple providers, describe how the primary PROS provider will maintain a unified case record for each recipient.
   vii. if applicable, plan to relocate PROS components to a single site; include timeframes.
c. Describe your plan to assure knowledge of, and coordination of services for, recipients who:
   i. access service components provided by another PROS program.
   ii. access treatment services of other mental health providers/programs other than a PROS program including clinic services. This must be addressed if the proposed PROS program is either Limited or is a Full PROS program without a clinical component.

4. Quality Improvement

a. Describe the organizational structure, including resources and staff, to implement the Quality Improvement process within the PROS program.
b. Describe initial plans for collecting, analyzing, and using outcome data for monitoring and improving services within the program, to include data regarding hospitalizations, ER visits, employment and discharges.
c. Describe your plans for participating in county/ provider agreements pursuant to 512.14. If available, include a copy of the agreement with deliverables identified. Describe how the program will respond to a recipient's request to change to another PROS provider.

Section J - Attachments (continued)

5. Evidence-Based Practices

a. Confirm the program's commitment to implementing and integrating evidence-based practices into the PROS program in cooperation with OMH and with the county.
b. Describe your plans for providing, and for assuring staff competencies in, the following evidence-based practices: family psycho-education; integrated treatment for co-occurring mental health and substance disorders (only for PROS with clinical); medication management (only for PROS with clinical); wellness self-management (i.e. illness management and recovery); and supported employment.
c. Describe plans for assuring staff competency in providing evidence-based practices, including regular and consistent education for staff, use of supervision to reinforce staff competency, and integration of evidence-based practices performance expectations into staff evaluations.

6. Employment

a. Describe your understanding of integrated, competitive employment and the program's philosophy regarding employment as it relates to recovery.
b. Describe the plan to address the employment needs of participants, including how staff will be trained to handle this critical area.
c. Describe how employment-related services will be integrated within the PROS program, including how those services will assist participants to obtain integrated, competitive employment.
d. Describe how PROS Vocational Initiative deficit funding will be used to enhance the employment-related services you will offer. Identify the vocational placement specialist on your staffing plan.
e. Describe plans to apply to become an employment network (EN) if your agency is not already designated as such.

7. Linkages with Other Providers

a. Describe plans to assure recipient access, as needed, to other mental health programs (for example: inpatient, other outpatient programs, case management, etc.) and to other services (for example: health, social services, housing, employment networks, etc.). Identify specific providers and programs or services. Indicate how appropriate clinical information will be shared.
b. Describe the program's plan to utilize VESID services and how these services will be coordinated with the PROS program. Describe how the program will transition PROS participants from VESID services back to the PROS program for employment support services.

8. Access

a. Describe how the PROS program will respond to recipients who need assistance during hours when the program is not in operation.

9. Cultural Competence

a. Provide demographics of the proposed service area, including economic, cultural and ethnic characteristics of the population.
b. Describe how the cultural, ethnic and linguistic needs of each recipient will be determined.
c. Describe the mechanisms by which the program will address the cultural and ethnic characteristics in the treatment of the population described above including identification of relevant linkages and resources in the community.
d. Describe the mechanisms by which the program will address linguistic needs of the population served by the PROS program (for instance: deaf persons, persons with limited English-speaking ability).

10. Implementation

a. Describe start-up or phase-in activities necessary to begin initial operation as a licensed PROS program. Include anticipated timeframes in your description. Activities should include staff hiring and training, physical plant modifications, etc.
b. If applicable, describe any additional implementation activities necessary for the licensed PROS to achieve full compliance with the requirements of Part 512. Include timeframes in your description.
c. If applicable, provide a detailed plan for a transition period pursuant to Part 512.16(b) for conversion of a CDT and/or IPRT to PROS. Include timeframes in your plan.
d. If applicable, provide justification for a waiver request pursuant to Part 512.15.

Section J - Attachments (continued)

11. Governance - Complete this section only if the PROS will be operated by multiple organizations. [Refer to Part 512.6(d)]

a. Identify the organization requesting the PROS operating certificate as the primary provider of services (Refer to section 512.4(ad) and 512.4(ak) of the regulations). Explain if this organization is not the same as the applicant listed in Section B (Page 1) of this application.

b. Identify each organization that together will operate the PROS program under contract with the primary provider of services identified in 10(a) above. For each organization include the following:

i. Name of organization
ii. Mailing address of organization
iii. The PROS component or PROS services provided by the organization
iv. Address(es) where the PROS component or PROS services will be provided
v. Reasons for entering into the proposed contract with the primary provider
vi. Copy of the proposed contract
vii. Information required under Section H (1) of this application (Ownership, Character, and Competence)
viii. Information required under Section I (1) of this application (Disclosure)

c. Describe how the primary provider of services identified in 10(a) above will:

i. Directly provide at least one PROS component including services, staff, and site
ii. Demonstrate sufficient resources and capability to manage and coordinate the entire PROS program including governing body responsibility, management and clinical staff, and financial resources
iii. Coordinate or provide Medicaid billing capability on behalf of the PROS program
iv. Coordinate or provide quality management and quality improvement functions including implementation of evidence-based practices, throughout the entire PROS program
v. Enter into provider agreements with the local governmental unit or with OMH pursuant to 512.14(b) of the regulations on behalf of the PROS program. Assure compliance with the requirements of Part 512 throughout the PROS program.

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Part II - Physical Plant

1. Identification of Applicant

a. Applicant's Name: _____

b. Applicant's Address:

Number and Street: _____

City, State, Zip Code: _____

Property Identifier

Please refer to **Part I, Section C - Project Description, Item 3** when completing this section.
Use a separate Physical Plant sheet for each property site.

Check appropriate box: ☐ Primary Site ☐ Multi-site Property # _____ of _____ (Example: 1 of 3)

2. Property Information:

a. Address of Proposed Premises: _____

b. Owner of Premises:

Name: _____

Number and Street: _____

City, State, Zip Code: _____

Approximate size of property:

c. Approximate size of property: _____ Sq. Ft.

d. Building size:

Number of floors: _____

Total Sq. Ft. in building: _____ Sq. Ft.

Identify floors to be used: _____

Amount of space to be used: _____ Sq. Ft.

Program space capacity: _____

e. Accessibility:

Is the program space handicap accessible?

☐Yes ☐No If no, explain: _____

Is the program accessible by public transportation?

☐Yes ☐No If no, explain: _____

3. For Leased Property:

a. Term of lease agreement:

Example: 1 year, 5 years

_____

b. Is the lease renewable? ☐Yes ☐No

c. Annual rental 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 a copy of the proposed lease ONLY for location(s) not currently certified by OMH for an outpatient program operated by the applicant.

4. Space Utilization Plan:
Submit plan showing room arrangement, dimensions, and proposed use of rooms and space. Describe proposed renovations if applicable.

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

6. Readiness Review:
Complete a site visit by OMH Field Office staff prior to issuance of an operating certificate.

Appendix A - Comprehensive PROS Services Checklist		
PROS Services Checklist - Comprehensive PROS	**Select if provided by the applicant or provided via contract to the applicant.**	**Identify contracted provider where applicable**
1. Admission Services		
a. Pre-Admission Screening		
2. Community Rehabilitation & Support (CRS)		
a. Assessment		
b. Basic Living Skills Training		
c. Benefits & Financial Management		
d. Community Living Exploration		
e. Crisis Intervention		
f. Engagement		
g. Individualized Recovery Planning		
h. Information & Education Regarding Self-Help		
i. Structured Skill Development & Support		
j. Wellness Self-Management* including:		
i. coping skills training		
ii. disability education		
iii. dual disorder education		
iv. medication education and self-management		
v. problem-solving skills training		
vi. relapse prevention planning		
3. Intensive Rehabilitation (IR)		
a. Family Psychoeducation*		
b. Intensive Rehabilitation Goal Acquisition		
c. Intensive Relapse Prevention		
d. Integrated Treatment for Co-occurring MH/SA* (IDDT)		
4. Ongoing Rehabilitation & Support (ORS)		
a. Ongoing Rehabilitation & Support*		
5. With Clinical Treatment Component		
a. Clinical Counseling and Therapy		
b. Health Assessment		
c. Medication Management*		
d. Symptom Monitoring		
e. Psychiatric Assessment		
6. Additional Services (written approval by OMH required):		

*Evidence-Based Practices

Appendix B - Limited License PROS Services Checklist		
PROS Services Checklist - Comprehensive PROS	**Select if provided by the applicant or provided via contract to the applicant.**	**Identify contracted provider where applicable**
Intensive Rehabilitation (IR) and Ongoing Rehabilitation and Support (ORS)		
a. Pre-Admission Screening		
b. Individualized Recovery Planning		
c. Intensive Rehabilitation Goal Acquisition (IR)		
d. Ongoing Rehabilitation & Support (ORS)		
e. Other (specify):		

Appendix C - Conversion Chart

Instructions: This chart is intended to identify the existing program/service components that will "convert" (no longer exist) by becoming the new PROS program.

Information Required	Program #1	Program #2	Program #3	Program #4	Program #5
Name of existing Program or Service as listed on the Consolidated Budget Report (CBR) (Identify provider if different than applicant)					
Current Site (Address)					
OMH Operating Certificate #, if applicable					
Agency Code (Existing)					
Program Code (Existing)					
Capacity, if applicable (Existing)					
Medicaid Provider Locator Code, if applicable					
Address upon conversion to PROS, if different from current location					
Is the entire program or service converting to PROS?					
If No, explain what will happen to the remaining program or service when the PROS program is licensed.					

Please attach additional pages if needed.