

**Western New York Care Coordination Program  
Application for Prior Approval Review  
14 NYCRR 551**

**INSTRUCTIONS**

**Who Must Complete This Application Form**

This application should be used for all participating providers of the Western New York Care Coordination Program subject to prior approval by the Office of Mental Health in accordance with Part 551 of 14 NYCRR.

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 NYCRR.

**Contents of the PAR Application Form**

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**Project Information**

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**Where to Send the Application**

Send 6 copies (including an original) to:

Jim McQuide, Director  
Bureau of Inspection and Certification  
NYS Office of Mental Health  
44 Holland Avenue  
Albany, NY 12229

Send an information copy to the appropriate local governmental unit pursuant to Section 551.8(b).

**Discard this page before submitting application.**

# Western New York Care Coordination Program Comprehensive Application for Prior Approval Review

## INSTRUCTIONS

### Application Form

The Western New York Care Coordination PAR application 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.

### Core Application

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

### Project – Specific Information

The rest of the submission should include only information relevant to the type of project under consideration. Refer to **Part I, Section C** of the application form and to the following guidelines:

Section	Page	Type of Project	Complete these Sections
C (1)	2	Establish new satellite	D, E, F, G, H
C (1)	2	Expand program at current site	D, E, F, G,

**Discard this page before submitting application.**



**Western New York Care Coordination Program  
Comprehensive Application  
for Prior Approval Review  
14 NYCRR 551**

<b>OMH USE ONLY</b>	
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	Name of Organization

**Section B - General Information**

<p><b>1. Identification of Applicant</b></p> <p><b>a. Name of Applicant</b></p> <p>_____</p> <p><b>b. Address</b></p> <p>_____</p> <p>No. &amp; Street</p> <p>_____</p> <p>City, State, Zip Code</p> <p>_____</p> <p>County</p> <p><b>c. Legal Name of Applicant (if different from above)</b></p> <p>_____</p> <p><b>d. Phone Number of Applicant</b></p> <p>_____</p> <p><b>e. Medicaid Provider Number (if any)</b></p> <p>_____</p> <p><b>f. Fax Number of Applicant</b></p> <p>_____</p> <p><b>g. E-Mail Address of Applicant</b></p> <p>_____</p> <p><b>2. Identification of Contact Person</b></p> <p><b>a. Name of Person to Contact for Additional Information</b></p> <p>_____</p> <p><b>b. Address of Contact Person</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>c. Phone Number of Contact Person</b></p> <p>_____</p>	<p><b>d. Fax Number of Contact Person</b></p> <p>_____</p> <p><b>e. E-Mail Address of Contact Person</b></p> <p>_____</p> <p><b>3. Type of Applicant</b></p> <p><b>Public</b></p> <p><input type="checkbox"/> State</p> <p><input type="checkbox"/> County</p> <p><input type="checkbox"/> Municipal</p> <p><b>Proprietary</b></p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Limited Liability Company</p> <p><input type="checkbox"/> <b>Not for Profit Corporation</b></p> <p><input type="checkbox"/> <b>Other (specify)</b></p> <p>_____</p> <p><b>4. Type of Facility Operated by Applicant (check all that apply)</b></p> <p><input type="checkbox"/> General Hospital (Article 28 PHL)</p> <p><input type="checkbox"/> Diagnostic and Treatment Center (Article 28 PHL)</p> <p><input type="checkbox"/> Psychiatric Center (state-operated)</p> <p><input type="checkbox"/> Hospital for the Mentally Ill</p> <p><input type="checkbox"/> Residential Treatment Facility for Children and Youth</p> <p><input type="checkbox"/> Outpatient Facility</p> <p><input type="checkbox"/> Residential Facility</p> <p><input type="checkbox"/> <b>Other (specify)</b></p> <p>_____</p>
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**Section B - General Information (Cont'd)**

**5. Applicant Experience**

- 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 Affiliation (if applicable)**

Identify any networks in which 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**

*(Check all that apply)*

**1.  Expand Existing Program Services**

- at primary program site
- at existing satellite location(s)
- establish new satellite location(s)
- establish new satellite locations through subcontracting arrangement

Name of Primary Program or Satellite	Operating Certificate No.	Expiration Date
Name of New Satellite(s)		
Address of New Satellite(s)		
Operating Days and Hours at Site	Counties to be Served by Expanded Program	

**Section D - Program Information**

**1. Services Checklist**

*Check all services provided by the program*

**a. Outpatient Programs**

Program	Required Services	Additional Services	Services by Other Providers <i>(specify provider)</i>	Optional Services <i>(specify)</i>
<b>Clinic Treatment For Adults</b>	<input type="checkbox"/> assessment and treatment planning <input type="checkbox"/> health screening and referral <input type="checkbox"/> discharge planning <input type="checkbox"/> verbal therapy <input type="checkbox"/> medication therapy <input type="checkbox"/> medication education <input type="checkbox"/> symptom management <input type="checkbox"/> psychiatric rehabilitative readiness determination <input type="checkbox"/> *crisis intervention (Satellite in Correctional Facility)	<input type="checkbox"/> case management <input type="checkbox"/> crisis intervention <input type="checkbox"/> clinical support	<input type="checkbox"/> case management <input type="checkbox"/> crisis intervention <input type="checkbox"/> health screening and referral <input type="checkbox"/> psychiatric rehabilitative readiness determination	
<b>Continuing Day Treatment</b>	<input type="checkbox"/> assessment and treatment planning <input type="checkbox"/> health screening and referral <input type="checkbox"/> discharge planning <input type="checkbox"/> case management <input type="checkbox"/> medication therapy <input type="checkbox"/> medication education <input type="checkbox"/> symptom management <input type="checkbox"/> psychiatric rehabilitative readiness determination and referral <input type="checkbox"/> rehabilitative readiness development	<input type="checkbox"/> supportive skills training <input type="checkbox"/> activity therapy <input type="checkbox"/> verbal therapy <input type="checkbox"/> crisis intervention <input type="checkbox"/> clinical support	<input type="checkbox"/> case management <input type="checkbox"/> crisis intervention <input type="checkbox"/> health screening and referral <input type="checkbox"/> psychiatric rehabilitative readiness determination and referral	
<b>Intensive Psychiatric Rehabilitative Treatment</b>	<input type="checkbox"/> psychiatric rehabilitative readiness determination <input type="checkbox"/> psychiatric rehabilitative goal setting <input type="checkbox"/> psychiatric rehabilitative function and resource assessment <input type="checkbox"/> psychiatric rehabilitative service planning <input type="checkbox"/> psychiatric rehabilitative skills and resource development <input type="checkbox"/> discharge planning			



**Section F - Financial**

**1. Operating Budget**

Based on Local Fiscal Year: \_\_\_\_\_ Jan-Dec \_\_\_\_\_ July-June

OPERATING EXPENSES	Phase-In Year	Operation During First Full Fiscal Year Inflation rate used is: _____ %	Operation During Second Full Fiscal Year Inflation rate used is: _____ %
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 Revenue Costs <i>(specify on a separate sheet)</i>			
Other Expenses <i>(specify)</i>			
<b>TOTALS:</b>			
<b>OPERATING INCOME</b>			
Patient Fees			
Medicaid:			
<input type="checkbox"/> Base Revenue			
<input type="checkbox"/> Current COPS Supplement			
<input type="checkbox"/> New COPS Supplement			
Medicare:			
Third Party Payments			
Direct State Expenditures (State Programs)			
Federal Grants <i>(specify)</i>			
Contributions <i>(specify each type such as: from individual, other groups, etc.)</i>			
Government Support			
<input type="checkbox"/> Local Assistance Regular			
<input type="checkbox"/> CSS			
<input type="checkbox"/> Other Government Income <i>(specify each funding source)</i>			
Other Revenue			
<b>TOTALS:</b>			

**Section F - Financial (Cont'd)**

**2. Expected Utilization for outpatient programs:**

	Phase in Year	1st Full Year	2nd Full Year
<b>Total Recipient Visits</b>			
Total Individual Visits			
Total Group Visits			
<b>Medicaid Visits</b>			
Individual Visits			
Group Visits			
<b>Caseload</b>			
<b>Program Capacity</b>			

**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 programs, what percentage of visits are projected to be 5 or more hours in duration?**

\_\_\_\_\_%

**3. Is the applicant presently designated as a COPS provider for any outpatient program?**

YES     NO

**a. Describe how designation as a COPS provider affects fiscal projection and operational capabilities of the program.**

**b. Has a COPS rate been anticipated and included in the Medicaid revenue projections under the "OPERATING INCOME" section of the preliminary budget?**

YES     NO

If "YES," please provide the rates and rationale utilized in developing the budget.

**Section G - 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 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:

**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:

**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:

**4. Will clinical services 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 the following information:

- a. Reasons for entering into the contract.
- b. Copy of the proposed contract.
- c. Background on the principals, officers, and directors of the organization consistent with Section H (1) of this application.
- d. Information in sufficient detail to enable review of the project pursuant to 551.7(a)(15).

## Section H - New Satellite Locations

### 1. Character and Competence (subcontracted satellites only)

- a. Identify the provider's name and address.
- b. Identify the provider's management personnel and structure.
- c. Identify the provider's Board of Directors and identify their occupation, community and philanthropic experience, and any conviction for any offense against the Law (except traffic charges) and explanation of charges pending in court.
- d. Provider experience in mental health and whether State Aid funding is received.

### 2. 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.

### 3. Implementation

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

### 4. 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. **Services** – Provide a detailed description of all subcontracted services available to recipients admitted to the program. Specify how these services will be provided and the staff position responsible for providing the service.
- e. **Staffing** – Include the qualifications and duties for each staff position. Provide a rationale for the proposed staffing plan.
- f. **Staff Supervision** – Describe how staff supervision will be provided at the specific satellite location.
- g. **Quality Assurance/Improvement** – Describe your plans for utilization review, incident management, and internal monitoring.
- h. **Premises** – Provide a description of the premises to be used by the program. Include appropriately labeled sketch drawings showing use and dimensions of rooms.