CRISIS STABILIZATION CENTERS

CERTIFICATION PROPOSAL
PRIOR CONSULT
ATTACHMENT 1A

This form must include Local Government Unit (LGU), OMH Field Office (FO), and OASAS Regional Office (RO) signatures. Include this form with submission of the Certification Application as proof of prior consultation with the LGU, FO, and RO. Please note that this document is not an application.

Section 1
Entity/Administrative Information

Applicant's Legal Name (Existing Entities Only)		Proposed Program Name	
Building/Building #	Room/Suite	Floor	PO Box or Postal Route
Street Address			
City	Town	Village	
State	Zip Code + 4	Telephone Number (including Area Code)	
Name of Contact Person		Position/Affiliation with Applicant	
E-Mail Address of Contact Person		Telephone Number of Contact Person	

☐ New Entity not currently Certified by OMH, OASAS or DOH

☐ Entity currently Certified by ☐ OMH ☐ OASAS ☐ DOH

Section 2
Proposal Information

Check the box that identifies the proposed action.

☐ Intensive Crisis Stabilization Center ☐ Supportive Crisis Stabilization Center

Section 3
Service Identification

Provide a description of the geographic area where the applicant plans to provide treatment services and describe how the service will function within the network of providers in this area.

Please describe outreach to the local community (e.g., Community Service Boards, Community Boards, Planning Boards, Neighborhood Coalitions, other local municipalities). Please summarize community input, including any existing or likely community concerns, as well as any recommendations. Include date(s) and the name(s) of the local community officials.
Provide an assessment of the need for crisis stabilization services within the proposed geographic area and include supporting data (i.e., Waiting lists, ER presentations, CPEP data, managed care organizations, etc.)

Section 4 Signatures		
Applicant Representative (Print Name)	**Applicant Representative Signature**	**Date**
LGU Representative (Print Name)	**LGU Representative Signature**	**Date**
Recommendation for the provider to submit a Certification Application ☐		
LGU Comments		
OMH FO Representative (Print Name)	**OMH FO Representative Signature**	**Date**
Recommendation for the provider to submit a Certification Application ☐		
OMH FO Comments		
OASAS RO Representative (Print Name)	**OASAS RO Representative Signature**	**Date**
Recommendation for the provider to submit a Certification Application ☐		
OASAS RO Comments		