NEW YORK STATE | Office of Mental Health

Comprehensive Prior Approval Review Application Prior Consultation Form

The purpose of the Prior Approval Review (PAR) Prior Consultation is to support providers in outlining the proposed project. This form should be submitted to the Local Governmental Unit (LGU) and OMH Field Office in advance of the prior consultation meeting. The proposed project and form will be reviewed during the prior consultation. Once the LGU and Field Office have completed the prior consultation and are in support of the applicant submitting a PAR application they will sign Part 2 of the form. Note, the LGU and Field Office signatures' do not constitute an agreement or inference that the proposed project will be approved or denied upon receipt of a formal application.

Date of Consultation:

Meeting Attendees	**Organization**	**Name(s)**	**Title(s)**
	Applicant participant(s)		
	Local Government Unit(s)		
	OMH Field Office Representative(s)		

PART 1: Project Summary

To be completed by applicant

Agency Name:

Agency Type:

Public:	☐ State	☐ County	☐ Municipal
Proprietary:	☐ Corporation	☐ Limited Liability Company	
Not-For-Profit:	☐ Corporation		

Application Type:

Program Type:

Counties to be Served:

Indicate the age range to be served: *Minimum Age:* up to *Maximum Age:*

Applicant Request:

Agency Background and Experience Operating Mental Health and Human Services Programs:

Need:

Applicant operates programs licensed by OMH: ☐ No ☐ Yes

Program Name	**Program Type**	**Operating Certificate #**

Applicant operates programs licensed by another NYS agency: ☐ No ☐ Yes

State Agency	**Program Name**	**Program Type**	**License Number**

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Describe how the agency will ensure board members, stockholders, or owners have experience operating licensed Article 31 mental health programs.

	Staff Title	Credentials	Full Time Equivalent (FTE)
Proposed Staffing Plan:			
	Total FTEs:		

Outpatient Programs: *Clinical Staff/Caseload Ratio:* *Average Census:*

CPEP Programs: *Total number of Extended Observation Beds:*

Inpatient/RTF/Residential Programs: *Current Bed Capacity:* *Proposed Bed Capacity:*

	First Full Year of Program Revenue		First Full Year of Program Expenses	
Proposed Budget	Medicaid:	$	Staff Salaries:	$
	Medicare:	$	Fringe Benefits:	$
	Commercial Insurance:	$	Administrative Costs:	$
	Grants:	$	Rent/Mortgage:	$
	Other, Specify:	$	Other Than Personnel Services:	$
	Total Revenue:	$	**Total Expenses:**	$
	Total Surplus/Deficit:			

Fiscal Comments:

PART 2: Prior Consultation Confirmation
To be completed by OMH and LGU Staff

Meeting Notes

OMH Field Office Staff Name	**Signature**
Local Government Unit Staff Name	**Signature**