Comprehensive Prior Approval Review Application
14 NYCRR 551

Instructions

Who Must Complete the Comprehensive Prior Approval Review (CPAR) Application

This application should be used for all projects subject to a comprehensive prior approval by the Office of Mental Health (OMH) in accordance with Part 551 of 14 New York Codes, Rules, and Regulations (NYCRR), including outpatient, inpatient, crisis, and residential programs. Consult Part 551 of the regulations for further reference and the Prior Approval Review website for a list of the types of projects that require a Comprehensive PAR Application.

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.

Completing the CPAR Application

Prior Consultation: Applicants shall participate in Prior Consultation meeting(s) with the Local Governmental Unit and the OMH Field Office before submitting the CPAR Application. Applicants shall complete the Prior Consultation Form (Appendix I of this application) and present it at the prior consultation. If the CPAR Application is not submitted within six months following the Prior Consultation meeting(s) the applicant will be expected to request and complete the Prior Consultation process again.

Part 1 Core Application: All applicants must complete Sections A-E. Complete only those items within each section that are relevant to the project. Indicate "not applicable" to items as appropriate. Attach additional sheets with section titles and items clearly labeled if more space is needed.

Part 2 Project Specific Sections: The table below outlines which sections of this Part must be completed based on the type of project. In addition, for all new programs by a new provider to OMH, complete and attach any related program specific addendum which can be found on the Prior Approval Review webpage. If there are multiple types of projects occurring within the application (e.g., expanding an inpatient program and capital project) then the applicant must complete all relevant sections. Attach additional sheets with section titles and items clearly labeled if more space is needed. Discard all section pages that are not relevant to the project type prior to submission.

Type of Project	Sections to Complete
Establish a new program by a new provider	F, G, H, I, J, O
Establish a new inpatient or residential treatment facility program	F, G, J, O
Expand or reduce an existing inpatient program or residential treatment facility by greater than 15% or greater than 10 beds	J, L
Close an inpatient program or residential treatment facility	N
Change sponsor of a licensed program to a new sponsor not currently licensed by OMH (New sponsor shall complete the CPAR)	H, I, M, O
Applications that also include capital projects	J, K, O

Appendices: Additional items may be required and can be found in the Appendix.

Submitting the CPAR Application

Applicants must submit their completed CPAR Application and all related attachments in the Mental Health Provider Data Exchange (MHPD). Applicants who are not currently licensed by Office of Mental Health (OMH) and/or do not have access to MHPD must follow the instructions in Appendix II to gain the appropriate access in advance of submitting the CPAR Application.

Contents

Part 1: Core Application

All applicants must complete Sections A-E.

Section A - Acknowledgements

I certify that all information included and 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.

If a consultant is utilized, I certify that this application and related appendices were completed by the entity proposing the project with input and approval by the agency's leadership.

Signature of Chief Executive Officer or authorized person: _____ Date: _____

Print or Type Name: _____ Title: _____

Section B - General Information

1. Agency Information

a. Agency Legal Name:	
b. Address of agency headquarters including the zip + 4:	c. County:
d. Phone:	e. Website:

2. Agency PAR Contact Person

a. Name:	b. Address:	
c. Title:	d. Phone:	e. Email:

3. Consultant Information, if applicable

a. Consultant Agency:	b. Consultant Name:
c. Consultant Address:	d. Consultant Title:
e. Consultant Phone:	f. Consultant Email:

4. Agency Type

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

Section C - Project Description

1. Application Type:

☐ Inpatient or Residential Treatment Facility Program Reduction or Expansion: Complete items 2, 3, and 6
☐ CPAR also includes a Capital Project: Complete item 5 in addition to the other items requested.
Note: If the capital project is related to the establishment of a new outpatient program, item 4 is not required.

2. Program Type:

☐ **Outpatient:** Choose the program type
☐ **Inpatient Hospital Program:** Choose the program type
☐ **Licensed Residential Program – Children & Adolescents:** Choose the program type
☐ **Licensed Residential Program – Adults:** Choose the program type

3. Program Information

a. Program Name:

b. Address of the Program, including zip + 4:

c. County:

d. Age range to be served: *Minimum Age:* up to *Maximum Age:*

e. OMH Operating Certificate Number, if applicable:

f. Medicaid Management Information System (MMIS) Number:

g. National Provider Identifier (NPI) Number:

4. Establishment of a New Program

a. County(ies) to be Served:

b. Hours of Operation:

i. The program will operate 24 hours a day, 7 days a week ☐ N/A ☐ Yes

	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

ii. The program will offer additional hours by appointment ☐ No ☐ Yes

c. Outpatient Programs:

i. Clinical Staff/Caseload Ratio:

ii. Average Census:

iii. Extended Observation Bed Capacity *(CPEPs Only):*

d. Inpatient/RTF/Residential Programs:	i. Proposed Bed Capacity:

5. CPARs that include Capital Projects

a. Construction Type: Choose the construction type	b. Estimated Cost: $
c. Indicate if state-aid will be utilized for capital construction: ☐ No ☐ Yes	

6. Expansion/Reduction of an Inpatient or Residential Treatment Facility Program

a. OMH Licensed Capacity:	b. Proposed Capacity:

c. Provide the NYS Department of Health (DOH) Certificate of Need (CON) application number associated with the expansion or reduction, if applicable.

☐ CON Application Number: _____

☐ CON has not yet been submitted.

7. Inpatient or Residential Treatment Facility Program Closure

a. Current Census:	b. Proposed Date of Closure:

c. Provide the NYS Department of Health (DOH) Certificate of Need (CON) application number associated with the closure.

☐ CON Application Number: _____

☐ CON has not yet been submitted.

d. Confirm the understanding that the inpatient program cannot close until final approval of this CPAR and any corresponding CON.

☐ Confirmed

8. Change of Sponsor

a. Current Sponsor/Agency:	b. New Sponsor/Agency:

Section D – Staffing

For items requiring narrative responses in this section, include an attachment labeled, *"Section D – Staffing"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g. 7a).

1. Indicate the number of hours in a standard workweek of a full-time equivalent (FTE) staff position at the agency (e.g., 37.5, 40 hours per week):

2. Proposed staffing plan. For expansion or reduction applications, indicate the current and proposed staff.

Staff Titles	Credentials	Estimated Annual Salary in Whole Dollars	Number of FTEs
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
Total FTEs:			

3. Submit a seven-day staffing schedule that shows appropriate coverage consistent with regulatory requirements for the program type. Include titles, hours or shifts worked, on-site or remote, days worked, on-call coverage, and crisis coverage.

4. Submit an organizational chart that identifies the lines of supervision for clinical staff. Include the titles and credentials of each staff.

5. Indicate the required experience, education, credentials, and duties for each staff position. Include the experience each staff position is expected to have with the population to be served. Describe the supervision and training that will be provided to support staff in serving the target population.

6. Describe how clinical supervision will be provided to staff including frequency and format. If applicable, describe how supervision will be provided to remote staff.

7. Describe program efforts including documented data-driven goals to recruit, hire and retain people with lived experiences, multilingual staff, and staff from the most prevalent cultural groups of the individuals to be served. Identify:
   a. The number of executive, supervisory, and direct care staff that are multilingual, have experience working with, or are from the most prevalent cultural groups to be served.
   b. Efforts to ensure employment opportunities reach diverse populations and use diversity-focused language in employment postings to reduce selection bias.

Section E - Financial

For items requiring narrative responses in this section, include an attachment labeled, *"Section E – Financial"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g. 3a).

1. Indicate the Fiscal Year: ☐ January - December ☐ July - June

2. Complete and attach the budget tool found on the PAR website that corresponds with the program type.

   MHOTRS programs **must** complete the MHOTRS Financial Calculator.
   CMHRS programs in the 5 Boroughs of New York City, Nassau, Suffolk, Westchester, Rockland, Putnam, Orange, Dutchess, Sullivan, and Ulster Counties **must** complete the Downstate CMHRS Budget Tool.
   CMHRS programs in all other New York counties **must** complete the Upstate CMHRS Budget Tool.
   All other programs **must** complete the PAR Budget Tool.

3. Describe the logic and assumptions used for each budgeted line item.
   a. Provide a breakdown of revenue by payor source if it is not already included in the budget. Explain the methodology used to derive revenue by payor source.
   b. Describe how administrative and overhead costs will be utilized and provide a breakdown of costs.
   c. If patient fee revenue is indicated in the budget, provide a list of patient fees.
   d. If grant revenue is indicated, identify the source of the grant, sponsor, any deliverables, or other stipulations attached to the funds, and the timeline of the grant.

4. Indicate the insurance plans with whom the agency has or plans to establish contracts.

5. Indicate if the agency will provide sliding scale fee options for under or non-insured individuals. If so, provide the sliding scale.

6. Describe program development costs (i.e., costs prior to program operation) and financing.

7. Describe how the agency will cover any projected deficit. ☐ N/A

8. Describe how staff salaries and fringe benefits are adequate to recruit and retain staff. Include any benefits packages being offered to staff.

9. Submit the last three (3) years of financial statements prepared by a certified public accountant. If the entity has been established for less than three (3) years, submit all available financial statements which may include financial statements for each incorporator, member of the board of directors, stockholder, or individual owner. This item is not applicable to applicants who are state, county, or municipal agencies.

Part 2: Project Specific Sections

Complete the sections required based on the type of project in the instructions on Page 1. Discard all section pages that are not relevant to the project type prior to submission.

Section F - Demonstration of Need for the Establishment of New Programs Submit a complete narrative response to all items in this section labeled, “Section F – Demonstration of Need”. Clearly identify the item number each response corresponds to (e.g., 5a).
1. Provide demographic data for the target population within the proposed service area. Describe the cultural and language needs of the target population. Provide a description of the specific communities the proposed program will be located in. Describe the geographic landscape of the proposed service area and indicate any barriers to accessibility including transportation.
2. If applicable, describe how the agency or program currently serves the target population.
3. Describe any service gaps including the unmet needs of the target population based on the availability of services within the service area. Research and identify similar programs, including OMH-licensed programs and document all outreach and findings related to these efforts.
4. Review the County Local Service Plans and summarize how the proposed program meets the needs of any of the local or regional behavioral health goals, if applicable.
5. Analyze the information provided above and describe how the proposed program will meet the needs of the service area and target population.

Section G - Program Information

Submit a complete narrative response to all items in this section labeled, "Section G – Program Information". Clearly identify the item number each response corresponds to (e.g. 4d(ii)).

1. Access and Equity

a. Describe how the program will serve the economically disadvantaged and medically indigent.

b. Provide the organization's diversity, inclusion, equity, and linguistic competence plan as outlined in the National CLAS Standards. Additional information about the National CLAS Standards can be found on OMH's Workforce Diversity and Inclusion.

c. Describe how the program will meet the language access needs of the individuals to be served and indicate any language access services that will be utilized. This may include individuals who are limited English proficient; deaf or hard of hearing (ASL); vision impaired (Braille); or have limited reading skills.

d. Describe plans to enable persons with physical disabilities to access services.
   i. If applicable, describe how the program will ensure telehealth services are accessible for persons that are deaf or hard of hearing.

e. Describe the program building's current Americans with Disabilities Act (ADA) accommodations.

f. Indicate the transportation arrangements through which individuals will access the program.

g. Describe how the hours of operation will accommodate the needs of the population to be served, including flexible scheduling, evening, and weekend hours, if applicable.

h. Identify the management-level person responsible for coordinating efforts to reduce disparities in access, quality, and treatment outcomes for marginalized populations. This includes activities related to diversity, inclusion, equity, and linguistic competence. Include the individual's title, education, credentials, and relevant experience.

i. Describe the organization's committees and membership that focus on diversity, inclusion, and equity activities. This should include how committees:
   i. Review services and programs with respect to cultural competency issues within the agency.
   ii. Correspond and collaborate with the quality assurance components of the agency.
   iii. Participate in planning and implementation of services within the agency.
   iv. Transmit recommendations to the executive level of the sponsor and agency.
   v. Ensure membership includes representatives from the most prevalent cultural groups to be served by this program and people with lived experiences.

2. Continuity of Care

a. Describe how the proposed program will function within the existing system of care.

b. Provide a plan to ensure continuity of care within the mental health system and with other service systems.

c. Indicate specific relationships the agency has with other providers in the service area to ensure referrals and linkages within the community.

d. For outpatient programs, describe a plan by which individuals enrolled in the program will be assisted during hours when the program is not in operation such as the agency's observed holidays.

e. For outpatient programs, describe the program's after-hours crisis plan.
Note: If the after-hours response will be provided through a contracted agency, complete Section H (4) for a clinical services contract.

3. Implementation

a. Identify all start-up or phase-in activities necessary to implement the program such as staff recruitment, onboarding, and insurance contracting. Include the timeframe for completing each activity.

b. Indicate the proposed date the program will begin providing services.

4. Functional Program

a. **Agency Mission**
   i. Provide a mission statement as well as an overview of the proposed program, that describes the treatment philosophy and includes information about the intent to serve individuals from marginalized and underserved populations.

b. **Organization**
   i. Describe the lines of authority from the governing body to the proposed program.
   ii. Describe the mechanism for participation of individual and family representation within the governing body or, if applicable, recipient advisory board.

c. **Goals and Objectives**
   i. Describe the goals, objectives, and expected outcomes of the program.
   ii. Indicate the anticipated average length of stay.

d. **Admission**
   i. Identify admission criteria. Include all inclusionary admission criteria, processes, timeframes, record-keeping, and procedures for notifying families and programs in which individuals are currently admitted.
   ii. Describe the assessment process and identify the initial assessment tools that will be utilized.
   iii. Describe any factors limiting admission to the program (e.g., fiscal, diagnostic, geographic, etc.)
   iv. Explain the process and timeframes for triaging individuals for screening and referring individuals who are not admitted.
   v. Identify the relationships the program currently has in the service area with other programs for referrals.

e. **Program Services**
   i. Describe each of the services the program intends to offer. Ensure all required services based on the program type are included as outlined in applicable guidance and regulations. Indicate any additional services that will be provided and include these in the response. The description should include:
      - Explanation of how these services will be provided including evidence-based practices that will be utilized.
      - Indicate the staff, including their credentials, responsible for providing the service.
      - Identify the trainings, resources, and supports that will be available to staff to enhance their knowledge and competencies for the provision of these services.
      - Explain the training that will be provided to staff regarding individual and family engagement and retention in treatment.
   ii. Indicate if the program will provide services via telehealth:
      ☐ No ☐ Yes: Attach copies of the program's telehealth policy and a completed attestation.
   iii. Indicate if the program intends to offer services offsite.
      ☐ No ☐ Yes: Describe when and how services would be provided offsite.
   iv. For new inpatient program, indicate if the program will provide Electroconvulsive Therapy (ECT).
      ☐ No ☐ Yes: Refer to the CPAR guidance document for what to include in the request for ECT.
   v. Describe how the program will coordinate with individuals' collaterals, families, schools, and other providers.

f. **Discharge**
   i. Describe discharge criteria. Include the process, timeframes, record-keeping, and procedures for notifying families and programs to which individuals will be referred for further services.
   ii. Describe the process for individuals lost to contact. Include outreach efforts, timeframes, and plans for rapid re-engagement based on an individual's assessed risk.

g. **Quality Assurance/Improvement**

i. Describe the following processes and practices for ensuring continuous quality improvement in the program. Include the responsible individuals, frequency, as well as related committees and memberships.

- Utilization review
- Incident management
- Collection and use of participant feedback to inform service delivery
- Review of grievances and complaints which ensures timely resolution and process if the individual identifies the resolution is not satisfactory

Section H - Agency: Character & Competence

For items requiring narrative responses in this section, include an attachment labeled, *"Section H – Agency Character & Competence"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g. 4a).

1. Submit the following document(s), where applicable. Check all that are enclosed with the application:
   - ☐ Certificate of Incorporation
   - ☐ Certificate of Amendment of the Certificate of Incorporation
   - ☐ Corporation By-Laws
   - ☐ Limited Liability Company Articles of Organization
   - ☐ Limited Liability Company Operating Agreement
   - ☐ Administrative Organizational Chart that identifies the executive staff, board members, and the overall sponsor and agency structure.

2. List all mental health and human service programs operated, managed, or affiliated with your agency during the last ten (10) years.

Program Name	Program Type	Years of Operation	County(ies) Served	Address	License Number	State Regulatory Agency
						Choose an item
						Choose an item
						Choose an item
						Choose an item
						Choose an item
						Choose an item

3. For each program listed, attach the most recent licensing visit report from the applicable oversight entity.

4. Indicate if management, clinical services, or administrative functions of the program will be provided by individuals who are not employees of the applicant or by organizations other than the applicant in compliance with 551.7(a)(14).
   - ☐ No ☐ Yes: Submit documentation required in items a-d for all individuals or organizations the statement applies to:
     a. Name of the individual(s) or organizations(s).
     b. Reasons for entering into the proposed contract.
     c. Submit a copy of the contract.
     d. Complete Section E: Ownership, Character & Competence for each principal, officer, LLC member, stockholder, and member of the board of directors of the contracted organization.

5. Indicate if any shareholders, members, or owners will also be a paid staff member.
   - ☐ No ☐ Yes. Submit the following:
     a. Conflict of Interest Policy that address how potential conflicts regarding employees that are also shareholders, members, or owners are addressed. This may include disclosure of conflicts, recuse from voting, etc.
     b. Bylaws or operating agreement that includes a provision to allow employees to serve on the board, if applicable.

6. Describe any additional information substantiating the character, competence, and standing of the organization.

Section I - Ownership: Character & Competence

Include the completed form as an attachment labeled, "Section I – Name of Individual CC Form" for ***each*** incorporator, member of the board of directors/governing body, corporate shareholders or LLC members, or individual owner. For items requiring narrative responses, include an additional attachment labeled, *"Section I – Name of Individual CC Responses."* Clearly identify the item number each response corresponds to.

1. Name of Individual:	2. Date of Birth:
3. Occupation:	4. Business Address:
5. Home Address:	
6. Primary Email Address:	7. Primary Phone:

8. Indicate the individual's relationship to the agency and additional information regarding their affiliation, including but not limited to their title, percentage of shares held, and percentage of voting rights, if applicable.

9. Indicate whether the individual named above in this section has/have a real property interest in the land, building, or equipment used by the program(s).

☐ No ☐ Yes: Describe the nature of the interest in detail.

10. Indicate whether the individual named above in this section has/have any relatives who have a real property interest in the land, building, or equipment used by the program(s).

☐ No ☐ Yes: Describe the nature of the interest in detail.

11. Indicate whether the individual named above in this section has/have any ownership of other partnerships, companies, or corporations that have a real property interest in the land, building, or equipment used by the program(s).

☐ No ☐ Yes: Describe the nature of the interest in detail.

12. Explain any convictions for all offenses under the laws of New York or any other jurisdiction. For purposes of this request, offenses shall include felonies or misdemeanors as defined under the laws of the jurisdiction within which such offenses took place; and convictions shall mean the entry of a plea of guilty; a verdict of guilty; or pleas of "no contest" or "nolo contender."

☐ Not Applicable ☐ Attached

13. List all mental health and human service programs operated by, managed by, or affiliated with the individual named herein during the last ten (10) years including positions held as an employee, owner, or member of the board of directors:

Program Name	Title(s) Held	Years Involved	Address of Program	State Regulatory Agency
				Choose an item
				Choose an item
				Choose an item
				Choose an item
				Choose an item
				Choose an item
				Choose an item

14. Indicate all relevant network or organization affiliations.
15. Describe any relevant community and philanthropic experience of the individual named herein.
16. Provide any additional relevant information substantiating the character, competence, and standing of the individual named herein.

Section J - Facility Description

For items requiring narrative responses in this section, include an attachment labeled, *"Section J – Facility Description"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g. 1c(ii)).

1. Property Information:

a. Address of proposed premises including the zip + 4:

b. Building Size:

i. Total number of floors in building:

ii. Floors to be used by program:

iii. Total square footage in building:

iv. Square footage of the space to be used by program:

c. List all other occupants, businesses, or programs located in and around the building of the proposed space. Provide a shared space agreement if applicable.

d. Indicate whether the property will be owned by the applicant or if the property will be leased.

☐ Leased: Proceed to 2. ☐ Owned by applicant: Proceed to 3.

2. Leased Property Information:

a. Name of the owner of the premises:

b. If the owner is a corporation, include the names of all incorporators and directors:

c. Term of the lease agreement:

d. Effective Date of Lease:

e. Indicate if the lease is renewable: ☐ No ☐ Yes

f. Annual cost per square foot:

g. Estimated total rental cost per year:

h. Attach a copy of the proposed lease.

i. Describe the landlord's access to the property and program space, if any.

j. Confirm the lease includes the following language: "The landlord acknowledges that rights of reentry into the premises set forth in this lease do not confer on the landlord the authority to operate on the premises a facility for the mentally disabled, as defined in article 1 of the Mental Hygiene Law." (14 NYCRR Part 551.10)

☐ Confirmed

3. Describe how the premises will ensure a therapeutic environment that meets the needs of the program and the population to be served.

4. Attach a clearly labeled scaled floor plan of the proposed program space.

5. Zoning and Permitted Uses:

a. If a Certificate of Occupancy is available at the time of the application, submit it with the CPAR. *A Certificate of Occupancy will be required prior to final approval.*

b. Indicate if the proposed use of the premises is acceptable under current zoning:

☐ No: Proceed to c. ☐ Yes

c. If no, indicate if approval has been requested from the local authority:

☐ No: *Evidence of approval will be required prior to final approval*

☐ Yes: If received, attach evidence of the local authority's approval.

6. Licensed Housing Programs:	a. For all licensed housing programs, attach evidence that the site selection process has been initiated pursuant to Section 41.34 of the Mental Hygiene Law and any responses received to date.
7. Crisis Residence Programs:	a. Indicate if the crisis residence will be the sole occupant of the building. ☐ No ☐ Yes: Submit a National Fire Protection Association 101 Life Safety Code Checklist found in Appendix III of this form.

Section K - Capital Project

Complete the sections that align with the type of capital project proposed. For items requiring narrative responses in this section, include an attachment labeled, *"Section K – Capital Project"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g., 2a(i)(A)).
*Note: This section is **not** required for applicants requesting to establish a new outpatient program, even if a capital project is included.*

1. New Construction Projects/Substantial Renovations

a. Indicate the type of project: Choose an item

b. For substantial renovation projects, indicate the estimated replacement cost: $

c. Residential Programs:

i. Indicate whether project financing will include state aid capital:
☐ No: Complete A-B ☐ Yes: Complete C-D

A. Explain how the capital project will be funded.

B. Submit a Construction Document Set prepared by a registered architect or professional engineer.

C. Indicate if a Capital Construction Project Justification Form has been submitted to the OMH Field Office.
☐ No ☐ Yes: Date of Submission: _____

D. Indicate if a Construction Document Set has been submitted to the OMH Central Office Bureau of Housing Development and Support.
☐ No ☐ Yes: Date of Submission: _____

d. Inpatient Programs

i. Describe the plan to ensure patient safety during construction. Include timeframes and impact on census, if applicable, for each phase of the project.

ii. Submit hardware specifications. Describe how the program will assess for and mitigate any potential ligature risks.

iii. If applicable, provide the NYS Department of Health (DOH) Certificate of Need (CON) application number associated with the capital project. If there is not a DOH CON application, provide an explanation as to why a CON application was not submitted.
☐ CON Application Number: _____
☐ N/A

2. Acquisitions

a. Projects for acquisition of property valued at greater than $600,000, must provide the following:
☐ Proposed contract of sale.
☐ Proposed use of space showing sufficient and appropriate space to support requested use, including program, capacity, and utilization.
☐ Analysis as to compliance with appropriate building and safety codes.

b. Indicate whether project financing will include state aid capital:
☐ No ☐ Yes

3. Alterations

a. Submit architectural plans prepared by a registered architect or professional engineer showing the room arrangement with the utilization of each room and space.

b. Submit an analysis of the proposed premises as to compliance with appropriate building and life safety codes. For inpatient programs, submit hardware specifications. Describe how the program will assess for and mitigate any potential ligature risks.

4. Leased Properties

a. Estimated cost to applicant for capital improvement:

b. Applicant's method of financing capital costs:

- ☐ Included in lease agreement
- ☐ Applicant's cash investment
- ☐ Other, specify:

5. All Capital Projects: Scope and Timeline

a. Describe the project scope in detail. For phased construction projects, provide a detailed description of each phase.

b. Provide a proposed project timetable. Indicate the anticipated timeframe from start to completion for each phase listed below.

Phase	Start (Month/Year)	Completion (Month/Year)
Preliminary Architectural Drawings		
Final Architectural Drawings/Specifications		
Bidding Documents		
Bidding of Project		
Awarding of Contracts		
Commencement of Construction or Renovation		
Completion of Construction/Renovation		
Commencement of Program Operation		

c. Review and complete all items related to capital projects in Section O: Additional Requirements Prior to Final Approval.

Section L - Inpatient or Residential Treatment Facility Program Expansion or Reduction of an Existing Program by Greater than 15% or Greater than 10 Beds Submit a complete narrative response to all items in this section labeled, "Section L – Inpatient Expansion/Reduction." Clearly identify the item number each response corresponds to (e.g., 4a).	
1. Provide justification and data supporting the need for the expansion or reduction.	
2. Describe the impact of the expansion or reduction on the service area. Explain how the agency has collaborated with other local providers, the local governmental unit, and the OMH to ensure that the needs of the service area are being met.	
3. Describe the impact of the expansion or reduction on services, staffing, and space.	
4. For programs expanding to serve children and adolescents:	a. Describe how the program will coordinate with the youth's family, school, and other child-serving systems.
	b. Describe the school programming that will be available while admitted to the program.
5. 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 M - Change of Sponsor

For items requiring narrative responses in this section, include an attachment labeled, *"Section M –Change of Sponsor"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g., 5b).

1. Describe the reasons for changing sponsorship of the program(s).

2. Indicate any financial considerations involved in the decision for a change of sponsor.

3. Indicate the following for all programs that will be changing sponsorship and/or provider of service based on the definitions outlined in 14 NYCRR Part 551.4:

Program Type	Operating Certificate #	Current Sponsor	Current Provider of Service	Proposed Sponsor	Proposed Provider of Service

4. Identify any changes to be made in operation of the program(s) listed above including, but not limited to, changes in services to be offered, capacity, location, service area, hours of operation, program manager.

5. Submit a transition plan, including time frames, for the change of sponsor that specifies:
   a. Notifications to individuals, family members, staff, local governmental unit, and other stakeholders.
   b. Transition of individuals receiving services.
   c. Transition and retention of staff providing services.
   d. Target filing date with Attorney General's Office and/or Department of State, as applicable.
   e. Proposed effective date for the change of sponsor.

6. Submit the following documents, as appropriate, based on the type of entity(ies) and change of sponsor:
   - ☐ Certificate of Incorporation
   - ☐ Certificate of Amendment of the Certificate of Incorporation
   - ☐ Limited Liability Company Articles of Organization and Operating Agreement
   - ☐ Certificate of Merger

7. Provide a signed written concurrence from the current sponsor for transfer of the program(s) to the proposed sponsor (e.g., resolution from the Board of Directors).

Section N – Inpatient or Residential Treatment Facility Program Closure

For items requiring narrative responses in this section, include an attachment labeled, *"Section N – Inpatient Closure"* that addresses all requested information. Clearly identify the item number each response corresponds to (e.g. 2g).

1. Describe the reasons for the proposed program closure and any efforts made to preserve operations.
   a. Describe the impact this closure will have on the service area.
   b. Describe how the agency will ensure that the needs of individuals being served will be met (e.g., expansion of other services, referrals, etc.).
   c. If the rationale for closure includes fiscal considerations, provide documentation to substantiate the lack of fiscal viability in the long term.
2. Submit a detailed transition plan that includes a timeline for each step. This should include:
   a. Description of the process for evaluation and placement of individuals.
   b. De-identified disposition list that identifies everyone admitted to the program, services individuals will be linked to based on their needs, follow-up, and confirmation of linkages to services.
      Note: This should not be attached to the application. Send to the appropriate OMH Field Office representative via email prior to OMH final approval.
   c. Confirm that individuals will be linked to appropriate alternative programs, which have agreed to accept the referrals, based on their assessed needs.
   d. Notification to individuals receiving services, family members, and stakeholders.
   e. Submit the plan for safeguarding individual's records and financial accounts.
   f. Description of other activities to conclude the affairs of the program.
   g. Proposed effective date of closure.
3. Provide signed written concurrence from the provider of service authorizing the closure (e.g., Resolution of the Board of Directors).

Section O - Additional Requirements Prior to Final Approval	
1. New Provider Applicants:	a. Ensure that at least one person can conduct Pre-employment Checks (PEC) using the Justice Center's Vulnerable Persons Central Register to run Staff Exclusion List checks, the Justice Center's CBC system to run Criminal Background Checks, and Office of Children and Family Service's Online Clearance System to run checks of the Statewide Central Register of Child Abuse and Maltreatment.
	b. Arrange the required PECs, if applicable, for each natural person owner of your organization: Staff Exclusion List, Criminal Background Check, and Statewide Central Register of Child Abuse and Maltreatment. The OMH PEC Specialist will email you the necessary forms and complete the checks.
	c. Complete a satisfactory pre-occupancy site visit, conducted by OMH Field Office staff, at the conclusion of the project prior to initiation of the program.
2. Change of Sponsor Applicants:	a. Submit an EZ PAR to close the licensed program(s) under the current provider of service, if the provider of service ceasing operation of the program is separate from the agency that is assuming operation.
	b. Contact the OMH Pre-employment Check Specialist to discuss what OMH Pre-Employment Checks may be required for any workers and volunteers from the subsumed entity who will stay with the merged entity.
3. If a Capital Project was Completed:	a. 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
	b. Submit a Certificate of Occupancy from the local building's jurisdiction.
	c. Complete a satisfactory pre-occupancy site visit, conducted by OMH Field Office staff, at the conclusion of the project prior to occupancy of the building or initiation of the program.

Appendix I: Prior Consultation Form

Comprehensive Application for Prior Approval Review Prior Consultation Form

The purpose of the Prior Approval Review Prior Consultation Form 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:

	Organization	**Name(s)**	**Title(s)**
Meeting Attendees	*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: Choose the application type

Program Type: Choose the program type

Counties to be Served:

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

Applicant Request:

Background:

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
Choose an item			
Choose an item			
Choose an item			
Choose an item			

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

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

Appendix II: Instructions for New Providers to Submit a Comprehensive Prior Approval Review Application

To submit a comprehensive prior approval review (PAR) application, applicants must have access to the Office of Mental Health's Security Management System (SMS) and Mental Health Provider Data Exchange (MHPD) applications. Applicants who are not currently licensed by Office of Mental Health (OMH) and/or do not have access to the secured OMH web-based applications mentioned above must complete the following steps to obtain the appropriate access in advance of submitting the comprehensive PAR (CPAR) application.

1. Following the prior consultation with the Local Governmental Unit (LGU) and the OMH Field Office, applicants will begin completing the PAR application form.
2. At least three (3) weeks in advance of submitting the PAR application, applicants must submit the "New to OMH Provider Contact Information Form" (found below) to the OMH Field Office.
3. Once the form has been processed by OMH, the applicant will receive an email from par@omh.ny.gov with the four-digit numeric facility code assigned to the applicant.
4. The applicant should then follow the steps for Enrollment in the Security Management System (SMS) outlined in the Guidance on Becoming a Licensed Provider (page 21 – 23).
5. Once the applicant has access to SMS, the security manager can grant users access to MHPD.
6. Within MHPD the applicant will select "Submit CPAR – Establish Program" or "Submit CPAR – Change of Sponsor." Complete required fields and attach all required sections of the Comprehensive Prior Approval Review Application as outlined in the Instructions (page 1).

For additional guidance or support contact the appropriate resource listed below:

- Obtain four-digit numeric facility code contact: OMH Prior Approval Review Unit or call 518-474-5570
- Access SMS or MHPD contact: ITS Service Desk or call 1-800-435-7697
- Complete the CPAR Application contact: OMH Field Office

New to OMH Provider Contact Information Form	
Provider	
Provider Name:	
Address:	
City:	State:
Zip + 4:	County:
Phone:	Fax:
Email:	
Executive Director/President/CEO	
Name:	Title:
Position:	Degree:
Phone:	Email:
Chairperson of the Board (if applicable)	
Name:	
Title:	Position:
Address:	
City:	State:
Zip + 4:	County:
Phone:	Email:

Appendix III: National Fire Protection Association 101 Life Safety Code Checklist

NFPA LIFE SAFETY CODE CHECKLIST

Compliance is mandatory for programs certified under Part 589, 594 or 595. Full compliance will typically be feasible for new construction. For alterations either (a) design to comply, (b) indicate additional work required for compliance and cost, (c) indicate which requirements are not technically feasible (provide detailed explanations.) Meet the requirements of the appropriate chapter and section (including those requirements incorporated by, reference) of NFPA Life Safety Code, 2012 Edition, pertaining to residential board and care facilities. If one or more of the code requirements cannot be met (in existing construction only) consider "equivalency concepts" as per Section 1.5 and NFPA 101A "Alternative approaches to life safety". The relevant chapters differentiate between new and existing building and between small and large facilities.

Part 594

CHAPTER 24 – ONE- AND TWO-FAMILY DWELLINGS

Part 589 and 595

CHAPTER 32.1 - NEW CONSTRUCTION GENERAL REQUIREMENTS

CHAPTER 32.2 - NEW CONSTRUCTION SMALL FACILITY

CHAPTER 32.3 - NEW CONSTRUCTION LARGE FACILITY

CHAPTER 33.1 - EXISTING BUILDING GENERAL REQUIREMENTS

CHAPTER 33.2 - EXISTING SMALL FACILITY

CHAPTER 33.3 - EXISTING LARGE FACILITY

(SMALL FACILITY IS 16 BEDS OR LESS)

This checklist must be completed by a license architect, engineer, or Life Safety
Code expert who is familiar with the property in question.

Program Type:

- ☐ Crisis Residence (Part 589)
- ☐ Adult Community Residence (Part 595)
- ☐ Children/Youth Community Residence (Part 594)

Property Street Address: _____ Bed Capacity: _____

City: _____

Is facility Small ☐ New ☐

Large ☐ Existing ☐

Specify construction classification. Refer to NFPA 220 Standard on Types of Building Construction:

A	**Specify evacuation capability of proposed population** (Existing Buildings only)		
32.2.1.2 32.3.1.2 33.2.1.2 33.3.1.2		Prompt	☐
		Slow	☐
		Impractical	☐
B	**Please answer the following questions for Part 594 facilities**		
	Indicate if means of escape comply with the following requirements:		
24.2.2.1	Number of means of escape	Y☐	N☐
24.2.2.2	Primary means of escape	Y☐	N☐
24.2.2.3	Secondary means of escape	Y☐	N☐
24.2.3	Arrangement of means of escape	Y☐	N☐
24.2.4	Doors	Y☐	N☐
24.2.5	Stairs, landings, ramps balconies or porches	Y☐	N☐
24.2.6	Hallways	Y☐	N☐
	Is protection provided as required by the appropriate chapter and section?		
24.3.3	Interior finish	Y☐	N☐
24.3.4.1	Smoke alarms or detection system	Y☐	N☐
24.3.4.2	Carbon monoxide and carbon monoxide detection systems	Y☐	N☐
24.3.5	Has automatic sprinkler system been provided?	Y☐	N☐
C	**Please answer the following questions for Small Part 589 or 595 facilities**		
	Indicate if means of escape comply with the following requirements:		
32.2.2.1 33.2.2.1	Number of means of escape/egress	Y☐	N☐
32.2.2.2 33.2.2.2	Primary means of escape/egress	Y☐	N☐
32.2.2.3 33.2.2.3	Secondary means of escape/egress	Y☐	N☐
32.2.2.4 33.2.2.4	Enclosure of interior stairs	Y☐	N☐
32.2.2.5 33.2.2.5	Doors	Y☐	N☐

32.2.3 33.3.3	Is protection provided as required by the appropriate chapter and section?	Y☐ N☐
32.2.3.1 33.2.3.1	Is protection of vertical openings provided?	Y☐ N☐
32.2.3.2 33.2.3.2	Is protection of hazardous areas provided?	Y☐ N☐
32.2.3.3 33.2.3.3	Do interior finishes comply with Section 10.2?	Y☐ N☐
32.2.3.4 33.2.3.4	Has a manual fire alarm with occupant notification and smoke detection been provided?	Y☐ N☐
32.2.3.5 33.2.3.5	Has an automatic sprinkler system been provided?	Y☐ N☐
32.2.3.6 33.2.3.6	Is protection of corridor walls and separation of sleeping rooms provided?	Y☐ N☐
D	**Please answer the following questions for Large Part 595 facilities**	
32.3.1.3 33.3.1.3	Does the building comply with minimum construction requirements?	Y☐ N☐
32.3.2.2 33.3.2.2	Do all components of escape/egress comply to the requirements of the appropriate chapter and section?	Y☐ N☐
32.3.2.3 33.3.2.3	Capacity of means of egress	Y☐ N☐
32.3.2.4 33.3.2.4	Number of exits	Y☐ N☐
32.3.2.5 33.3.2.5	Arrangement of means of egress	Y☐ N☐
32.3.2.6 33.3.2.6	Travel distance to exits	Y☐ N☐
32.3.2.7 33.3.2.7	Discharge from exits	Y☐ N☐
32.3.2.8-10 33.3.2.8-10	Illumination, Emergency lighting and Marking of exits	Y☐ N☐
32.3.3 33.3.3	Is protection provided as required by the appropriate chapter and section?	Y☐ N☐
32.3.3.1 33.3.3.1	Is protection of vertical openings provided?	Y☐ N☐
32.3.3.2 33.3.3.2	Is protection of hazardous areas provided?	Y☐ N☐
32.3.3.3 33.3.3.3	Do interior finishes comply with Section 10.2?	Y☐ N☐

32.3.3.4 33.3.3.4	Has a manual fire alarm with occupant notification and smoke detection been provided?	Y☐ N☐
32.3.3.5 32.3.3.5	Has an automatic sprinkler system been provided?	Y☐ N☐

32.3.3.6 33.3.3.6	Is protection of corridor walls and separation of sleeping rooms provided?	Y☐ N☐
32.3.3.7 33.3.3.7	Is subdivision of building spaces provided?	Y☐ N☐

If “no” is checked for any of the above, please explain.

_____

_____

_____

List all exceptions used.

_____

_____

_____

Has alternative approach to life safety been used? Y☐ N☐

If yes, state required code that could not be met, and attach FSES calculations for Residential Board and Care Facility (101A Chapter 7).

_____

***Please attach any related floor plans and/or drawings, as well as scope of work, narrative, and cost estimates. ***

_____

Signature and title of person completing this form

Name (printed):_____

Date:_____

Updated on 11/15/2023