NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Opioid Treatment Program - Application to Request Capacity Lift

Provider Name: **Date:**

Provider #: **PRU #:**

Provider Address:

Contact Person:

Contact Phone: **Contact email:**

Current Census: **Current # on waiting list:**

Attestation:

Our OTP requests the lifting of our capacity based on the following:

1. **Our program currently:**

☐ Has in place a scheduled dosing and counseling visit procedure for patients. *Please provide a detailed description of your scheduled dosing/counseling visit procedure:*

☐ Offers the following best practice services *(check all that apply):*

- ☐ Buprenorphine, Vivitrol and/or other addiction medications
- ☐ Ancillary withdrawal services
- ☐ Peer support/Recovery support services
- ☐ Plan to increase integration of physical and mental health services within the OTP setting
- ☐ Other clinically relevant services (other than required services) designed to improve patient care? If checked, please specify:

-OR-

2. **Our program has submitted with this application a detailed description of the proposed plan of the following changes to be fully implemented within 6 months of OASAS approval:**

   ☐ A scheduled dosing and counseling visit procedure for patients. (*Please provide a detailed description of your proposed scheduled dosing/ counseling visit procedure and rollout, plan for staff and patient education and inclusion in development, and implementation timeline):*

   ☐ At least one of the following best practice services** *(check all that apply):*

      ☐ Buprenorphine, Vivitrol and/or other addiction medications

      ☐ Ancillary withdrawal services

      ☐ Peer support/Recovery support services

      ☐ Plan to increase integration of physical and mental health services within the OTP setting

      ☐ Other clinically relevant services (other than required services) designed to improve patient care? If checked, please specify:

***Please provide a detailed description of your proposed plan to implement and rollout of new best practice service(s), plan for staff and patient education and inclusion development, and implementation timeline:*

Our OTP will need technical assistance for the above-referenced plan. Yes

I certify that the information above is current and accurate. Based on this application, our program qualifies for and is requesting an immediate lifting of capacity restrictions.

Signature: _____ **Date:**