STATE OF MARYLAND
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH ADMINISTRATION

HG §8-507 COURT ORDERED TREATMENT SERVICES APPLICATION FOR LICENSED COMMUNITY-BASED BEHAVIORAL HEALTH PROGRAMS

IMPORTANT: PLEASE READ INSTRUCTIONS BEFORE COMPLETING APPLICATION

This application packet should be used by programs licensed under COMAR Title 10, Subtitle 63 seeking to provide court ordered treatment services under Health General Article §8-507. In order to provide HG 8-507 services, a program must be a Maryland Medicaid approved provider in good standing, have completed all licensing requirements under COMAR Title 10, Subtitle 63, have obtained program accreditation, and, when applicable, meet all program conditions established by the Department for the treatment of Pregnant Women and Women with Children.

This is a fillable document, which means that you may complete it electronically. Please fill in the requested information completely. If this application is incomplete or missing any of the documentation required, the processing of the application will stop and the application will be returned to the applicant to provide the missing information.

Completed applications are reviewed in the order that they are received. Licensed programs applying to provide §8-507 services will receive confirmation from the Department that their application has been received in full.

Before a program can qualify to receive HG 8-507 treatment referrals, the Department, through Justice Services, shall conduct a four-hour on-site training and facility tour.

Should you have any questions regarding the application process or the additional program requirements contained in the Department's §8-507 providers manual, please contact the MDH Admissions Office at (410) 402-8522

Please send completed application to: mdh.bhajusticeservices@maryland.gov OR
MDH Justice Services
Hill Building, Spring Grove Hospital Center
55 Wade Ave
Catonsville, MD 21228

Section 1: PROVIDER INFORMATION

The corporate/business name of the provider/program must match what is registered with the Maryland Department of Assessments and Taxation (SDAT) and Maryland Medicaid. If something doesn't apply to you, mark "NA". If "NA" is marked, you may be asked to provide a reason the section doesn't apply to you, if the reason is not obvious.

Corporate/Business Name:		
Corporate Address:		
Corporate Website:		
Program Name (if different from Corporate Name)**:**		
Medicaid ID Number (MA#):		
Website (if different from Corporate Website)**:**		
Owner Name:		
Primary Contact:	**Phone:**	**Title:**
Primary Contact Email:	**Fax:**	
***Generic Program Contact Information:**		

*In case of staffing changes, this information will be used by the Department to communicate with the program noted above.

Section 2: CORRESPONDENCE ADDRESS INFORMATION

In the event that correspondence must be sent via the United States Postal Service, enter the Correspondence Address to which you want all your correspondence mailed. Please note that, when possible, communications will be sent via email.

Mailing Name/Address:

Section 3: Admissions Office Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section 4: LICENSED TREATMENT SERVICES

Please complete for all program(s) and/or service types that your program is licensed to provider under COMAR Title 10, Subtitle 63. Note, "capacity" means the total number of individuals that a program can accommodate.

Program Name:			
Program Address:			
County/Baltimore City:			
Total Capacity:	# Slots	# Female Beds	# Male Beds
Early Intervention Treatment Level 0.5 Program			
Outpatient Treatment Level 1 Program			
Intensive Outpatient Treatment Level 2.1 Program			
Partial Hospitalization Treatment Level 2.5 Program			
Residential- Low Intensity Level 3.1 Program			
Residential- Medium Intensity Level 3.3 Program			
Residential-High Intensity Level 3.5 Program			
Residential-Intensive Inpatient Level 3.7 Program			
Withdrawal Management / Opioid Treatment Services Level 4 Program			

Section 5: Potential Training Dates

MDH requires a four (4) hour on site visit in order to be approved as an 8-507 provider. The first two (2) hours of the day are a training and information session. MDH requires that, at a minimum, the provider's Program Director, Clinical Director, Admissions Director and Fiscal Manager attend the training and information session. Any other provider staff are also welcome to attend. Please provide at least 3 dates/times in the next 30-60 days that all required members of your staff will be available for the training and information session. . At least one member of the program staff must also be available immediately after the training and information session to guide MDH staff through the facility for a brief facility tour.

Section 6: ATTESTATION

I, ______________________________________ affirm the following:

1. ____ complies with and shall continue to comply with all applicable federal, state, and local ordinances, laws, regulations, transmittals, guidelines, orders, administrative service organization provider alerts, and provider manual instructions governing the program, including any and all program/service descriptions, specific staffing requirements, and appropriate staff credentials as they relate to the program(s)/service(s) identified in Section 4 of this application; and

2. I have read the requirements of an HG 8-507 provider as outlined in the most current version of *Certification Manual: HG 8-507 Court Ordered Treatment.* I agree to all requirements, including reporting, transportation, and supervision requirements, outlined in the manual.

____	______________________
(Signature)	(Date)
____	_____________________________________
(Printed Name)	(Title)

Section 7: REQUIRED SUPPLEMENTAL INFORMATION/DOCUMENTS

Please submit with this application, a copy of the following documents and answer any additional questions. If any required document is missing, this application will not be processed and will be returned to the applicant.

FOR ALL APPLICANTS:

- Copy of your current COMAR Title 10, Subtitle 63 Community-Based Behavioral Health Program License
- Copy of documented proof of the program's good standing status with Maryland Medicaid
- Copy of documented proof of the program's good standing status with SDAT
- Staff Directory with names, phone numbers and email addresses for all staff members
- Organization Chart for program
- Copy of program schedule.

Section 8: AUTHORIZATION

I, ____, the practitioner, administrator, or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief.

Signature: ____ Date: _________________

Printed Name: ____

Title: ____