

APPLICATION PACKET

Currently Certified Programs Only

COMAR 10.47 – ALCOHOL AND DRUG ABUSE ADMINISTRATION

Revised 7/1/17

This application packet may only be used by applicants/programs that are currently certified under COMAR 10.47 and who are seeking renewal of their certification, who wish to add/remove a service level, add a new site, or relocate to a new site. This is a fillable Word document, which means that you may complete it on your computer, print it out, sign where indicated, and then submit it.

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. Please note that **each program site** requires a separate application.

All complete applications are reviewed in the order that they are received. This is the most equitable way to prioritize the application review process. Due to the number of applications received, there may be a wait period before your application can be reviewed. We do appreciate your understanding.

If you need a copy of the regulations, please contact the Division of State Documents at (410) 974-2486 or Toll Free at (800) 633-9657, or go to the following web address to download the order form: <http://www.dsd.state.md.us/PDF/DHMHBooklets.pdf>. When completing the form to request COMAR booklets, **return that form and payment to: Office of the Secretary of State Division of State Documents • State House • Annapolis, MD 21401 Tel: 410-260-3876 • 800-633-9657 • Fax: 410-280-5647.** If you want to review the regulations on-line, please go to: <http://www.dsd.state.md.us/COMAR/ComarHome.html> and follow the instructions.

Please Return Completed Application to: **Stacey Diehl**

 **Behavioral Health Administration**

 **Spring Grove Hospital Center**

**Bland Bryant Building • 55 Wade Avenue**

 **Catonsville, MD 21228**

Should you have any questions about this application form, please contact the BHA Licensing Unit at (410) 402.8198.



**1) OWNER/BUSINESS INFORMATION:**  The corporate/business name of the provider/program must match what is registered with the Maryland Department of Assessments and Taxation (SDAT). 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:**       | **County:**  |
| **Corporate Website:**       |
| **Owner Last Name:**       | **First Name:**       |
| **Primary Contact:**       | **Phone:** (     )      -      | **Title:**       |
| **Primary Contact Email:**       @       | **Fax:** (     )       -       |

|  |
| --- |
| **Emergency Contact Name:**       |
| **Emergency Contact Home Address:**       |
| **Emergency Contact’s Office Phone:** (     )      -      |
| **Emergency Contact’s Cell Phone:** (     )      -      |
| **Primary Contact Email:**       @       | **Fax:** (     )       -       |

|  |
| --- |
| **Trade Name** (if different from legal name)**:**       |
| **Website** (if different from Corporate Website)**:**  |
| **Program Address:**  | **County:**  |
| **NPI #:**       |  |  |
| **Primary Contact:**       | **Phone:** (     )      -      | **Title:**       |
| **Primary Contact Email:**       | **Fax:** (     )       -       |
| **Hours of Operation** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
|  | **to**  | **to** | **to** | **to** | **to** | **to** | **to** |



**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.

[ ]  Corporate Name/Address

[ ]  Trade Name & Address

[ ]  Other:

Street Address:       City:       State:       Zip:

[ ]  Preferred Email Address:       @



**3) CURRENT CERTIFICATION INFORMATION:** A “Current Certification Number” is the registration or certification number issued to the program after the last survey and appears on the program’s Certificate of Approval issued by the Department. “Certification Expiration” is the expiration date found on the program’s Certificate of Approval issued by the Department.

**Current Certification Number:**       **Certificate Expiration Date:**



**4) CURRENT CERTIFICATION TYPE:** Please check all program and/or service types that the program is currently certified to provide. “Capacity” means the total number of individuals that a program can accommodate. *(See COMAR 10.47.02 through 10.47.02.11 & 10.47.03.03 through 10.47.03.07)*

|  |  |
| --- | --- |
|  | **Capacity** |
| **OUTPATIENT SERVICES** | **# Beds** | **# Adults** | **# Adolescentss** | **# Children** |
| [ ]  Level 0.5 Early Intervention |  |       |       |       |
| [ ]  Level 0.5 Early Intervention: DWI/DUI Education |  |       |       |       |
| [ ]  Level 1 Outpatient |   |       |       |       |
| [ ]  Level II.1 Intensive Outpatient |  |       |       |       |
| [ ]  Level II.5 Partial Hospitalization |  |       |       |       |
| **RESIDENTIAL SERVICES** |  |  |  |  |
| **[ ]** Level III.1 Clinically Managed Low Intensity Residential |       |       |       |       |
| [ ]  Level III.3 Clinically Managed Medium Intensity Residential |       |       |       |       |
| [ ]  Level III.5 Clinically Managed High Intensity Residential |       |       |       |       |
| [ ]  Level III.7 Medically Monitored Intensive Inpatient Treatment  *(requires Certificate of Need)* |       |       |       |       |
| **DETOXIFICATION SERVICES** |  |  |  |  |
| [ ]  Level I.D Ambulatory Detoxification w/o Extended On-site  Monitoring |  |       |       |       |
| [ ]  Level II.D Ambulatory Detoxification w/ Extended On-Site  Monitoring |  |       |       |       |
| [ ]  Level III.2-D Clinically Managed Residential Detoxification |       |       |       |       |
| [ ]  Level III.7-D Medically Monitored Inpatient Detoxification  *(requires Certificate of Need)* |       |       |       |       |
| **OPIOID MAINTENANCE THERAPY** |  |  |  |  |
| [ ]  OMT – Opioid Maintenance Therapy |  |       |       |  |
| [ ]  OMT.D\* – ONLY Opioid Maintenance Therapy  Detoxification *(\*check only if a State & Federally Approved*  *Opioid Treatment Program)* |  |       |       |  |
| **CORRECTIONAL SERVICE LEVELS** |  |  |  |  |
| [ ]  Correctional Level I |  |  |  |  |
| [ ]  Correctional Level II.1 |  |  |  |  |
| [ ]  Correctional Level II.5 |  |  |  |  |
| [ ]  Correctional Level III.1 |  |  |  |  |
| [ ]  Correctional Level III.5 |  |  |  |  |



**5) TYPE OF CERTIFICATION REQUESTED ON THIS APPLICATION:** Please note: this application may be used for a combination of certification requests (e.g. a renewal of certification request may also include a change in program location, or an addition or deletion of service level. Please check all that apply. **A separate application is required to be completed for each physical site, however.**

[ ]  Renewal of Certification [*see COMAR 10.47.04.04C]*

[ ]  Renewal Certification of Opioid Maintenance Therapy Program(s) *[see COMAR 10.47.02.11]*

[ ]  Change in Service Level Request [*see COMAR 10.47.04.03D]*

[ ]  Change of Program Location Request [*see COMAR 10.47.04.04.03G & 10.47.04.04D(6)]*

[ ]  Relocation of Certified Program [ ]  New Site Certification

* Current address:
* Proposed address:
* Is your new location ready for an on-site inspection at the time of application?

 **[ ]  Yes [ ]  No**

*If you answered “No”, what is the anticipated date that site will be ready for inspection:*

Insert Date (***NOTE:*** *Should not be more than 6 months from date of application submission.)*



**6) STAFFING INFORMATION:** Please provide the following information, as required by COMAR 10.47.01.06, for the required staff positions.

|  |
| --- |
| **Program Staff** |
| [ ]  Program Administrator’s Name:       |
| [ ]  Medical Director’s Name, if applicable:       |
| [ ]  Clinical Supervisor’s Name, if applicable:       |
| **Sponsor** *(required for Opioid Maintenance Therapy Programs only – see 42 CFR Part 8.2)* |
| [ ]  Sponsor’s Name:       |
| [ ]  Mailing Address:       |
| [ ]  Email Address:       |
| [ ]  Phone Number:       |



**7) SERVICE LEVEL REQUEST:**  Complete only if adding/changing service levels. New service level requests see COMAR 10.47.02.03 through 10.47.02.11 and 10.47.03.03 through 10.47.03.07. Check all that apply.

|  |  |
| --- | --- |
|  | **Capacity** |
| **OUTPATIENT SERVICES** | **#** **Beds** | **# Adults** | **# Adolescentss** | **# Children** |
| [ ]  Level 0.5 Early Intervention |  |       |       |       |
| [ ]  Level 0.5 Early Intervention: DWI/DUI Education |  |       |       |       |
| [ ]  Level 1 Outpatient |   |       |       |       |
| [ ]  Level II.1 Intensive Outpatient |  |       |       |       |
| [ ]  Level II.5 Partial Hospitalization |  |       |       |       |
| **RESIDENTIAL SERVICES** |  |  |  |  |
| **[ ]** Level III.1 Clinically Managed Low Intensity Residential |       |       |       |       |
| [ ]  Level III.3 Clinically Managed Medium Intensity Residential |       |       |       |       |
| [ ]  Level III.5 Clinically Managed High Intensity Residential |       |       |       |       |
| [ ]  Level III.7 Medically Monitored Intensive Inpatient Treatment  *(requires Certificate of Need)* |       |       |       |       |
| **DETOXIFICATION SERVICES** |  |  |  |  |
| [ ]  Level I.D Ambulatory Detoxification w/o Extended On-site  Monitoring |  |       |       |       |
| [ ]  Level II.D Ambulatory Detoxification w/ Extended On-Site  Monitoring |  |       |       |       |
| [ ]  Level III.2-D Clinically Managed Residential Detoxification |       |       |       |       |
| [ ]  Level III.7-D Medically Monitored Inpatient Detoxification  *(requires Certificate of Need from MHCC)* |       |       |       |       |
| **OPIOID MAINTENANCE THERAPY** |  |  |  |  |
| [ ]  OMT – Opioid Maintenance Therapy |  |       |       |  |
| [ ]  OMT.D\* – ONLY Opioid Maintenance Therapy  Detoxification *(\*check only if a State & Federally Approved*  *Opioid Treatment Program)* |  |       |       |  |
| **CORRECTIONAL SERVICE LEVELS** |  |  |  |  |
| [ ]  Correctional Level I |  |  |  |  |
| [ ]  Correctional Level II.1 |  |  |  |  |
| [ ]  Correctional Level II.5 |  |  |  |  |
| [ ]  Correctional Level III.1 |  |  |  |  |
| [ ]  Correctional Level III.5 |  |  |  |  |
| Program will provide services in *(Check all that apply)*: [ ]  Maryland Division of Correction [ ]  Local Detention Center |



**8) REQUIRED SUPPLEMENTAL DOCUMENTATION:** The following information must be submitted with this application. Failure to do so will result in your application being returned to you.

[ ]  **Governing Body**: A “Governing Body” is the organizational structure that is responsible for

establishing policy, maintaining quality care, and providing management and planning for the program. You must provide a roster of the member/members of the program’s governing body (see COMAR 10.47.01.03). The roster must contain the name as well as the mailing address of all members.

[ ]  **Organizational Chart**: The organizational chart shall show schematically the staff positions maintained

by the program, detailing lines of authority and responsibility, and the individual names of staff members currently employed in those positions, including all clinical staff employees.

[ ]  **Current Fire Inspection Report and Use and Occupancy Permit**, if adding a site or relocating to a new

site.

[ ]  **Proof of a “Good Standing”** status with the Maryland Department of Assessments and Taxation.

[ ]  **Staff Credentials**: If adding a new service level/new site, a copy of the credentials for all staff requiring a license/certification

[ ]  **Certificate of Need (CON):** If providing Level III.7 or Level III.7-D services, you must include a copy of the CON issued by the Maryland Health Care Commission.

[ ]  **Policy & Procedures :** If adding a new service level, you must include policies & procedures as they relate to the specific level you are adding.

[ ]  **DWI Services:** If you are adding DWI services, you must submit your curriculum for those services.

[ ]  **Detoxification Services:** If you are adding detoxification services, you must submit detoxification protocols for the following: 1. The physician, nurse, clinical staff and non-clinical staff; 2. Nursing Assessment; 3. Physical exam; and 4. Monitoring of vitals.

[ ]  **Opioid Maintenance Therapy:**  Programs that wish to be certified to provide Opioid Maintenance Therapy (OMT) must also apply to the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Controlled Substances Administration (OCSA), and the Drug Enforcement Administration (DEA). Please contact SAMHSA, OCSA, and DEA directly to apply.



**9) REQUIRED STATISTICS**

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| --- |
| [ ]  Number of individuals receiving services at the time of application:       |
| [ ]  Language/Communication Services: Please check all language/communication services to be provided: [ ]  Spanish [ ]  American Sign Language [ ]  Services for the Hearing Impaired  [ ]  Other Language Service(s):       |
| [ ]  Population Type: The program will serve: [ ]  Adolescents (12-17 years of age) [ ]  Adult Males [ ]  Adult Females [ ]  Pregnant Women [ ]  Women with Children |
| [ ]  Program will provide Mental Health Services (check only one): [ ]  Co-Occurring Enhanced *(refer to the American Society of Addiction Medicine – Patient Placement*  *Criteria)* [ ]  Co-Occurring Capable *(refer to the American Society of Addiction Medicine – Patient Placement*  *Criteria)* |



**10) ATTESTATION THAT PROGRAM COMPLIES WITH SPECIFIC PROGRAM & SERVICE DESCRIPTION(S).**

I, Insert Name am affirming that Insert Corporate/Business Name is in compliance and will remain in compliance with all applicable regulations, 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 and/or 7 of this application.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature) (Date)



**11) ATTESTATION OF COMPLIANCE WITH RELEVANT FEDERAL, STATE, OR LOCAL ORDINANCES, LAWS, REGULATIONS, AND ORDERS GOVERNING THE PROGRAM.**

I, Insert Name, am affirming that Insert Corporate/Business Name shall 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature) (Date)



**12) AUTHORIZATION:** I, Insert Name, 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.

Date:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Helpful Links & Contact Information:**

MHCC: <http://mhcc.maryland.gov/> or call (410) 764-3460.

SAMHSA: <http://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs> or call (877) 726-4727.

OCSA: <https://health.maryland.gov/OCSA/Pages/home.ASPX> or call (410) 764-2890.

DEA (Washington DC Division) Contact Info: <http://www.dea.gov> or call (202) 305-8500.