



MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

Behavioral Health Administration

55 Wade Avenue • Dix Building SGHC • Catonsville, MD 21228

Barbara J. Bazron, Ph.D., Deputy Secretary & Executive Director

APPLICATION FOR A RECOVERY RESIDENCE CERTIFICATE OF COMPLIANCE

IMPORTANT: PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

In accordance with HB 1411, all residential facilities considered as “recovery residences” must receive a certificate of compliance from the Maryland Behavioral Health Administration on or before October 1, 2017. Enclosed you will find an application which must be completed by any applicant seeking a certificate of compliance for a recovery residence.

“**Recovery Residence**” means a service that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders or addictive disorders or co-occurring mental health substance-related, or addictive disorders. Recovery residences provide Marylanders housing in a safe and healthy environment that supports residents in initiating and sustaining their recovery. Recovery residences, though, formal and informal peer support, empower, strengthen, and sustain the emergent healthy lifestyles of residents as they transition toward independent and productive lives in their respective communities.

Before applying for certification, please review the Compliance Documentation Checklist to identify documentation requirements. **A separate application is required for each service site location.**

Please type or print legibly all required information. Failure to fill in required information or provide supporting documentation will delay the application being processed until all required information is received. Please retain a copy of the application and attachments for your files.

Return Completed Application to: Mail: Maryland Certification of Recovery Residences
Behavioral Health Administration
Hill Building
55 Wade Avenue
Catonsville, MD 21228
Email: mcorr.info@maryland.gov
Fax: (410)402-8601

Should you have any questions, please contact the Behavioral Health Administration (BHA) at (410) 402-8595.

Certification of Recovery Residences Application

A Certificate of Compliance is issued once your application is approved and the recovery residence has passed a site inspection conducted by the Behavioral Health Administration (BHA) or a contractor approved by BHA. **The certification is valid for one (1) year from the date of issuance.** Each applicant is required to submit additional documents to accompany this application. Please refer to the Documentation Checklist for a list of required documents.

Please select the type of application your organization would like to apply for:

Application Type:

Initial Certification

Application Change
_ Ownership
_ Location
_ Gender
_ Bed Capacity
_ Level of Support

Renewal Certification (Cert# _____)

Please review the list below and attach copies of the following documents. All documents are required and applications are not considered complete if the documents are not submitted with this application.

Checklist:

- _____ Proof of Property Ownership/Letter from Property Owner
- _____ Fire and Safety Inspection Report
- _____ Occupancy Report
- _____ Certificate of Insurance
- _____ Policy and Procedure Manual
- _____ Proof of Legal Business Entity
- _____ Staff Credentials
- _____ Resident Orientation Handbook

I. Applicant Information: (Required) The business name of the organization must be listed as it is registered with Maryland State Department of Assessment and Taxation.	
Organization(Full Name):	Legal Entity(Full Name):
Type of Organization: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> C-Corporation <input type="checkbox"/> S-Corporation <input type="checkbox"/> Limited Liability Company	Website:
Mailing Address: (City, State, Zip Code)	Program Email: Tax ID:
Main Office Phone Number:	Fax Number:
Owner's Name and Contact Number:	
Owner's Email Address:	
Program's Contact Number:	
Program's Email Number:	

1. Has the organization received any funding from the State of Maryland to support this service? If so, please list the following:

Funding Type: _____ MDRN/ATR _____ Contract w/County or City government
_____ Other _____

When? _____ 2017 _____ 2016 _____ 2015 _____ 2014 _____ 2013 _____ 2012 _____ 2011
(Check all that apply)

2. Maryland Certification of Recovery Residences (MCORR) values and encourages partnerships with Faith and Community –based organizations.

MCORR defines a Faith–Based Organization as:

- a religious congregation (church, mosque, synagogue, or temple) or,
- an organization, program, or project sponsored/hosted by a religious congregation (may be incorporated or not incorporated) or,
- a nonprofit organization founded by a religious congregation or religiously-motivated incorporators and board members that clearly states in its name, or incorporation, or mission statement that it is a religiously motivated institution or,
- a collaboration of organizations that clearly and explicitly includes organizations from the previously described categories.

(Faith Organization founded on a particular religion or spiritual belief)

Religious denomination: _____

Place a check mark in the box that best describes your organization.

- Community-Based
- Non-profit
- For- profit
- Grassroots (annual operating budget of \$500,000 or less)
- Other: _____

II. Staffing Information:

1. Organization’s Director(include Title):

Email:
Phone:

Emergency Contact Person:

Email:
Phone:

2. House Manager(Full Name):

Email:

Phone:

Is the House Manager compensated for job duties? If yes please check:

 free/partial room and board paid salary Other: _____

Hours on Duty: _____

III. Property Information	
Property Name:	Property Ownership: <input type="checkbox"/> owns property <input type="checkbox"/> leases from 3 rd party <input type="checkbox"/> leases from related person entity
Levels of Support: <input type="checkbox"/> I Peer Run <input type="checkbox"/> II Monitored <input type="checkbox"/> III Supervised <input type="checkbox"/> IV Service Provider	Type of Structure: <input type="checkbox"/> Single family <input type="checkbox"/> Multi-unit dwelling/apt.(#units____) <input type="checkbox"/> Facility Is this residence handicap accessible? _Y _N If yes, please describe:
Physical/Service Address: (City, State, Zip Code) County:	#Bedrooms <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other:_____
Billing Address: (City, State, Zip Code)	#Bathrooms <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other:_____

<p>Special Services: (check all that apply)</p> <input type="checkbox"/> offers American Sign Language interpretation <input type="checkbox"/> is universally accessible for individuals with disabilities <input type="checkbox"/> has a location near public transportation <input type="checkbox"/> has handicapped parking <input type="checkbox"/> offers service in languages other than English (If so, what language(s)?)	<p>Bed Capacity: ____</p>
<p>IV. Population Served</p>	
<input type="checkbox"/> Women <input type="checkbox"/> Men <input type="checkbox"/> Co-ed <input type="checkbox"/> Women with Children <input type="checkbox"/> LGBT <input type="checkbox"/> Veterans <input type="checkbox"/> Pregnant Women <input type="checkbox"/> Transitional Aged Youth	
<p>1. Is your organization abstinence based? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2. Does your organization accept individuals receiving medication assisted treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>3. Does your organization conduct routine drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>V. Resident Fees. (In this section, please indicate how often resident fees are collected, and select room type).</p>	
<p>Billing Frequency (how often resident fees is collected): <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> monthly</p> <p>Administrative Fees: _____ Security deposit amount: _____ Prorated amount: _____ First and Last Amount: _____</p> <p>Room Type: <input type="checkbox"/> Shared room amount: _____ <input type="checkbox"/> Private room amount: _____</p>	
<p>1. Is food included in the fees charged? If yes, how much? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>2. Who manages the residents' funds? _____</p>	

VI. Disclosures: (Required)

Complete **only** if your organization is not licensed or certified by, registered with, or otherwise accredited by or affiliated with an authority accepted by the Maryland Department of Health and Mental Hygiene, consistent with the qualification requirements of the Maryland Certification of Recovery Residences.

Has a prior license, certification, or approval issued within the previous five (5) years from any in-State or out-of-State provider previously or currently associated with your organization been revoked or surrendered?

- Yes
 No

If yes, please explain and provide a copy of any associated deficiency or compliance reports.

Has your organization or a program, corporation, or provider previously or currently associated with your organization surrendered or defaulted on its license, certification, or approval within the previous five (5) years for reasons related to disciplinary action?

- Yes
 No

If yes, please explain the nature of the disciplinary conduct.

Has any employee, staff, peers, or volunteer currently associated with your organization had a professional license or certification revoked or suspended or surrendered a professional license or certification for reasons related to disciplinary action or misconduct, within the previous ten (10) years.

- Yes Full name and date of birth of individual
 No

If yes, please explain the nature of the disciplinary action or conduct

Has any employee, staff, peer, or volunteer currently associated with your organization been convicted of a felony within the previous ten (10) years?

- Yes Full name and date of birth of individual
 No

If yes, please explain the nature of the disciplinary action or conduct.

Terms of Agreement Acknowledgement

By signing below, I certify that I have read and understand the Maryland Certification of Recovery Residences requirements. I have read and agree to comply with the National Association of Recovery Residences (NARR) standards and the Code of Ethics. I agree to the information provided in this application and attachments are correct and true to my knowledge.

Print Name:

Signature of Applicant’s Representative Title or Position Date

<i>For Maryland Certification of Recovery Residences office use only:</i>	
Date application received:	<input type="radio"/> Application approved
MCORR Director/Manager’s Signature:	<input type="radio"/> Application denied Reason:
	Decision Date: