



# 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: Patricia Konyeaso, Director  
Maryland Certification of Recovery Residences  
Behavioral Health Administration  
Vocational Rehabilitation Building  
55 Wade Avenue  
Catonsville, MD 21228  
Email: [mcorr.info@maryland.gov](mailto: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

Renewal Certification (Cert# \_\_\_\_\_)

<b>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.</b>	
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:
Billing Address: (City, State, Zip Code)	Tax ID:
Main Office Phone Number:	Fax Number:
<b>Owner's Contact Number:</b>	
<b>Owner's Email Address:</b>	
<b>Program's Contact Number</b>	
<b>Program's Email Number:</b>	
1. (For grandfathering) Is this organization an active member in <b>"good standing"</b> with the Maryland State Association of Recovery Residences (MSARR)? If so, please list the following:  MSARR Certification#: _____ Expiration Date: _____	

2. 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)

**3. 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	
<b>Property Name:</b>	<b>Property Ownership:</b> <input type="checkbox"/> owns property <input type="checkbox"/> leases from 3 <sup>rd</sup> party <input type="checkbox"/> leases from related person entity
<b>Levels of Support:</b> <input type="checkbox"/> I Peer Run <input type="checkbox"/> II Monitored <input type="checkbox"/> III Supervised <input type="checkbox"/> IV Service Provider	<b>Type of Structure:</b> <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:
<b>Physical/Service Address: (City, State, Zip Code)</b>  <b>County:</b>	<b>#Bedrooms</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other:_____
<b>Billing Address: (City, State, Zip Code)</b>	<b>#Bathrooms</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other:_____

<p><b>Special Services:</b> (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><b>Bed Capacity:</b> ____</p>
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**IV. Population Served**

Women  
 Men  
 Co-ed  
 Women with Children  
 LGBT  
 Veterans  
 Pregnant Women  
 Transitional Aged Youth

1. Is your organization abstinence based?  Yes  No

2. Does your organization accept individuals receiving medication assisted treatment?  
 Yes  No

3. Does your organization conduct routine drug testing?  Yes  No

**V. Resident Fees. (In this section, please indicate how often resident fees are collected, and select room type).**

Billing Frequency (how often resident fees is collected):  weekly  bi-weekly  
 monthly

Administrative Fees: \_\_\_\_\_  
 Security deposit amount: \_\_\_\_\_  
 Prorated amount: \_\_\_\_\_  
 First and Last Amount: \_\_\_\_\_

Room Type:  
 Shared room amount: \_\_\_\_\_  
 Private room amount: \_\_\_\_\_

1. Is food included in the fees charged? If yes, how much? \_\_\_\_\_  Yes  No

2. Who manages the residents' funds? \_\_\_\_\_

**V. 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 Provider Manual.

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

<b><i>For Maryland Certification of Recovery Residences office use only:</i></b>	
Date application received:	<input type="checkbox"/> Application approved
MCORR Director/Manager’s Signature:	<input type="checkbox"/> M-SARR Member Status Verified:
Date:	<input type="checkbox"/> Application denied Reason: