



Office of Health Care Quality

**Bland Bryant Building ♦ Spring Grove Hospital Center ♦ 55 Wade Avenue
Catonsville, Maryland 21228 ♦ (410) 402-8100 ♦ Fax: (410) 402-8270**

To: Existing & New Program Applicants – New Service Request

From: Office of Health Care Quality (OHCQ)
Community Mental Health Unit

Re: Program Application
Mental Hygiene Administration
Community Mental Health Programs

Enclosed is an application packet for certification/licensure under the Mental Hygiene Administration's (MHA) Community Mental Health Program regulations. An applicant must submit a separate application for each service requested. For example, an applicant wishing to provide both a Psychiatric Rehabilitation Program (PRP) and a Mental Health Vocational Program must submit a separate application for each, in accordance with the program specific instructions discussed below. Applicants applying to serve both adults and minors through a PRP may combine the applications. However, each PRP has unique program specific components that must be addressed when filing the application.

Included in this packet are:

1. Application Face Sheet
2. Attestation
3. OMHC Eligibility Form
4. Contact Numbers
5. Approval and Administrative Requirements - (COMAR 10.21.16 & .17)
6. Program Specific Requirements Addendums A – I
7. Business Plan Information Sheet Addendum J

Special Outpatient Mental Health Center (OMHC) Review Criteria

For an applicant seeking approval to become an **OMHC** under COMAR 10.21.20, an OMHC Eligibility Determination Form must be submitted along with the standard application. An OMHC application will not be considered until an eligibility determination review has been completed.

Residential Programs for Children and Youth

Applicants applying to become a Therapeutic Group Home, Respite Care Program or Residential Crisis Program for Children in a Residential Group Home setting must first attend the **Single Point of Entry - Interest Meeting** offered by the Governor's Office for Children (GOC) and be approved by the GOC prior to submitting an application to the Office of Health Care Quality.

An application must include the following:

- a. An Application Face Sheet (see below)
 - b. An Attestation (see below)
 - c. An OMHC Eligibility Form (For OMHC applicants only; not applicable for current providers) (see below)
 - d. A Business Plan Information Sheet
 - e. A narrative developed in response to each question on the Administrative Requirements Form outlined below. (Current providers highlighted sections only)
 - f. A narrative response for each applicable program specific requirement list as item #15 on the Administrative Requirements Form..
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Complete application packets should be sent to:

Mr. William Dorrill, Deputy Director
Residential and Community Programs
Office of Health Care Quality
Bland Bryant Building, Spring Grove Hospital Center
55 Wade Ave, Catonsville, MD 21228

&

The applicant's Lead Core Service Agency (CSA)

Copies of the *Application Face Sheet, OMHC Eligibility Form (if applicable), Program Service Plan and Business Plan Information Sheet* should be sent to:

Ms. Sharon Ohlhaber, Chief
Quality Management, Community Programs
Mental Hygiene Administration
SGHC, Mitchell Building
55 Wade Avenue
Catonsville, MD 21228

Application Face Sheet

Business Name: _____

Trade Name (if applicable): _____

Currently approved under MHA's Community Mental Health Program regulations:

YES Please identify: _____ NO

Address: _____

TAX ID#: _____

Contact Name and Affiliation:

Contact Number: _____ **FAX#:** _____

Email Address: _____

Location of Proposed Program (if different from above):

Please check the type of Community Mental Health Program you are applying for:

Check Service Type	Community Mental Health Program	Regulation
<input type="checkbox"/>	Psychiatric Day Treatment Services	10.21.02
<input type="checkbox"/>	Therapeutic Nursery Programs	10.21.18
<input type="checkbox"/>	Mobile Treatment Services	10.21.19
<input type="checkbox"/>	Outpatient Mental Health Center (OMHC)	10.21.20
<input type="checkbox"/>	Psychiatric Rehabilitation Programs for Adults (PRP)	10.21.21
<input type="checkbox"/>	Respite Care Services	10.21.27
<input type="checkbox"/>	Mental Health Vocational Programs (MHVP)	10.21.28
<input type="checkbox"/>	Psychiatric Rehabilitation Services for Minors	10.21.29
<input type="checkbox"/>	Group Home for Adults with Mental Illness (GH)	10.21.04

Attestation:

I, _____ (AUTHORIZED AGENCY REPRESENTATIVE), affirm that _____ (NAME OF BUSINESS ORGANIZATION) shall comply with all applicable laws and regulations concerning Medicaid and the establishment and operation of a community mental health program.

Please check all that apply:

- Program/Individual/Corporation _____ *has* or _____ *has not* had any license or approval revoked by the Department or other licensing agency in Maryland, DC or any other state;
- Program/Individual/Corporation or entity associated with the program _____ *has* or _____ *has not* surrendered or defaulted on its license or approval for reasons related to disciplinary action in Maryland, DC or any other state;
- Program/Individual/Corporation _____ *does* or _____ *does not* have a corporate officer who has served as a corporate officer for a corporation or entity that has had a license revoked, or has surrendered or defaulted on its license or approval for reasons related to disciplinary action within the previous 10 years.
- Program/Individual/Corporation or entity associated with the program _____ *has* or _____ *has not* been sanctioned by MHA, a professional/credentialing body or any other regulatory agency in the last 10 years.

SIGNATURE: _____

TITLE: _____

DATE: _____

The applicant must submit detailed information (e.g. names, dates, etc.) for each affirmative answer.

Administrative Requirements

The following **Administrative Requirements** must be satisfied by all applicants. An applicant who is currently approved as a provider under MHA's Community Mental Health Programs must complete the **bolded** areas for the new service being requested.

1. Verification that a representative from your agency has attended an Applicant Interest Meeting. Please contact Doris Williams at the Office of Health Care Quality (410-402-8060) to be placed on the waiting list for the next scheduled presentation.
2. A Program Service Plan (PSP) to include:
 - a. **The range of services that the program will provide;**
 - b. **The populations to be served, including age groups and other relevant characteristics, and the number of the individuals that the program expects to serve;**
 - c. **Program sites and hours of operation, and the method to ensure that services are accessible to the individuals served;**
 - d. **The goals, objectives, and expected outcomes of the program;**
 - e. The composition of the program's governing body, board of directors, or advisory committee, whichever applies, as outlined in COMAR 10.21.17.05;
 - f. **The jurisdictions where services will be provided and the number of services to be provided in each jurisdiction; and**
 - g. **The jurisdiction where most of the program's services will be rendered.**
3. A summary of the applicant's demonstrated experience in the field of mental health and, in particular, the applicants experience with the applicable Maryland regulations and funding requirements. In addition, **prior ASO/MHA audit reports issued within the previous 10 years from any entities associated with the program, including deficiency reports and compliance records must be submitted.**
4. Detailed information (e.g., names, dates, etc.) for each affirmative answer documented on the Attestation.
5. **All applicants applying to provide services to minors must be registered with CJIS-Central Repository and show evidence that background checks through the fingerprinting process have been initiated for the applicant and all identified staff. Submission of a completed criminal background check for the owners of the corporation, the board members and/or advisory committee members is required.**
 - a. The protocol to be used by the applicant in deciding the appropriateness of employing individuals with criminal histories. COMAR 10.21.17.14 D
6. **A Business Plan must be submitted in conformance with the Business Plan Instruction Sheet. (See attachment)**

7. **A protocol for ensuring compliance with the Human Resource and Development.(COMAR 10.21.17.11) that includes:**
 - a. **A detailed plan describing how the education and training needs of staff will be satisfied for both for initial and future hires**
 - b. **Identification of the individual(s) who will perform the training and their professional qualifications; and**
 - c. **The frequency of training/education for staff must be addressed.**
8. A Quality Management process (per COMAR 10.21.17.12).
9. **A protocol for ensuring compliance with staff are:**
 - a. **Properly credentialed for the job responsibilities assumed**
 - b. **Properly supervised based on the individual's credentials and job responsibilities**
 - c. **Privileged to perform duties in accordance with the individual's professional credentials.**
10. **A letter from the Core Services Agency that serves the area in which your program is be located that acknowledges the program's agreement to collaborate.**
11. A protocol for ensuring that all clients will receive Orientation, Discharge Services/Summary and Advanced Directive information in accordance with COMAR 10.21.17.04.
12. If the business through which the application is being made has been incorporated through the Maryland Department of Assessments and Taxation, the applicant must identify the corporate officers to comply with the provisions of COMAR 10. 21.17.05. This requirement is also applicable to foreign corporations.
13. **A procedure for the as needed referral of clients for somatic, psychiatric, vocational, rehabilitation, substance abuse treatment or other needed services.**
14. **A fire survey from the local or state fire department, which is dated within one year of the application submittal date. (10.21.16.03B)**
15. **Program Specific Requirements – Addendums A – I (As applicable)**
 - A- **Psychiatric Rehabilitation Programs for adults (COMAR 10.21.21)**
 - B- **Psychiatric Rehabilitation Services for Minors (COMAR 10.21.29)**
 - C- **Outpatient Mental Health Center (COMAR 10.21.20)**
 - D - **Mental Health Vocational Programs (COMAR 10.21.28)**
 - E - **Mobile Treatment Services (COMAR 10.21.19)**
 - F- **Psychiatric Day Treatment Services (COMAR 10.21.02)**
 - G- **Group Home for Adults with Mental Illness (COMAR 10.21.04)**
 - H - **Respite Care Services (COMAR 10.21.27)**
 - I - **Therapeutic Nursery Programs (COMAR 10.21.18)**

16. The following information can be submitted following completion of all other application requirements but must be submitted prior to issuance of the approval/license:

- a. **The identification of the specific individuals that will serve as the Program Director, Rehabilitation Coordinator, Medical Director, Multidisciplinary Team, Registered Nurse and the Rehabilitation Specialist, as applicable;**
- b. **Submission of the credentials, education, work experience, and a copy of Maryland License (if applicable), etc. for the individuals listed in 16(a).**

If you have any questions regarding this process, please contact Office of Health Care Quality's Community Mental Health Unit at 410-402-8060.

Website Information

- Office of Health Care Quality - Community Mental Health Unit (C-MHU)
 - Telephone Number: 410-402-8060 Fax: 410-402-8270

<http://www.dhmf.state.md.us/ohcq/index.html>
- Department of Health and Mental Hygiene(DHMH)
<http://www.dhmf.state.md.us/>
- Code of Maryland Regulations (COMAR)
<http://www.dsd.state.md.us/comar/>
- Mental Hygiene Administration (MHA)
<http://www.dhmf.state.md.us/mha/>
- Core Service Agency Directory
<http://www.dhmf.state.md.us/mha/csa.htm>
- ValueOptions
<http://maryland.valueoptions.com/>
- Governor's Office for Children (GOC)
www.goc.maryland.gov
- Criminal Justice Information Systems (CJIS)
<http://www.dpscs.state.md.us/publicservs/bgchecks.shtml>

ADDENDUM - A

**Psychiatric Rehabilitation Programs (PRP) for Adults
COMAR 10.21.21**

1. Please submit the program's policies and procedures that cover the documentation and implementation of the following:
 - a. Eligibility, Screening, and Initiation of Service.
 - b. Completion of assessments to include a review of the client's somatic status and housing needs.
 - c. Development or completion of the IRP and IRP reviews.
 - d. Documentation of contact notes that documents services delivered, significant events, incidents, etc.
 - e. Promotion of Individual Wellness Self Management and Recovery/Health Promotion and Training
 - f. Medication Monitoring or Administration (if applicable) and
2. Guideline for the delivery of rehabilitation and recovery services

ADDENDUM - B

**Psychiatric Rehabilitation Services for Minors (PRP for Minors)
COMAR 10.21.29**

Please submit the following information:

1. Guideline for the delivery of age appropriate rehabilitation and support services
2. The program's policies and procedures that cover the following:
 - a. Eligibility, Screening, and Initiation of Service.
 - b. Completion of assessments to include a review of the client's somatic status.
 - c. Development or completion of the IRP and IRP reviews.
 - d. Development or completion of contact notes that includes the reflection of rehabilitation and support services, resiliency, Promotion of Illness Management, significant events, incidents, etc.
 - e. Rehabilitation and Support Services.
 - f. Promotion of Individual Wellness Self Management and Recovery/Health Promotion and Training.
 - g. Staff training, required staff and staffing ratios (COMAR 10.21.29.09)

ADDENDUM – C

**Outpatient Mental Health Center (OHMC)
COMAR 10.21.20**

Please submit the following information:

1. Verification from MHA that the applicant meets the eligibility requirements as an OMHC (see Form Below)

2. The program's policies and procedures that covers the documentation and implementation of the following:
 - a. Eligibility, Screening & Enrollment to Services
 - b. Diagnostic Evaluations
 - c. Completion of assessments to include a review of the client's somatic status
 - d. Development of the ITPs and ITP reviews
 - e. Implementation of individual, family, & group therapy, medication education, medication monitoring, exchange of medical information
 - f. Medication Monitoring or Administration, if applicable
 - g. On-call services
 - h. Co-Occurring Substance Abuse screening assessment
 - i. Treatment of or referral for Co-Occurring Substance Abuse disorder
 - j. Staffing pattern including the identification of the program director, medical director, and multi-disciplinary team.
 - k. Multi-site staffing requirement

OMHC Eligibility Form

The following needs to be submitted for all applicants who are applying to be approved as an Outpatient Mental Health Center (OMHC).

All applicants applying to be an Outpatient Mental Health Center under COMAR 10.21.20 must submit evidence that they meet the requirement identified below:

10.21.20.03 Approval.

A. The following applicants shall be eligible for approval as an outpatient mental health center (OMHC), if the applicant demonstrates experience providing mental health services for a minimum of 1 year:

(1) A group practice; or

(2) A program currently approved under another Mental Hygiene Administration community mental health program chapter.

Please indicate below how your program meets the COMAR requirements identified above.

SIGNATURE:

PRINTED NAME:

TITLE:

DATE:

ADDENDUM – D

**Mental Health Vocational Programs (MHVP)
COMAR 10.21.28**

Please submit the following information:

1. Description of vocational a services, including Job Development, job placement, entitlement counseling and employment support services per COMAR 10.21.28.08
2. A contingency plan for staff availability to provide necessary vocational services in the absence of regularly scheduled staff
3. The program's marketing strategy to increase employment opportunities for the clients COMAR 10.21.28.08
4. The program's policy for the development of the vocational assessment, Individual Vocational Plan, Plan Review and continuing evaluation.

Please note: Supported employment is the only model funded by MHA 10.21.28.09

ADDENDUM - E

Mobile Treatment Services (MTS)
COMAR 10.21.19

Please submit the following information:

1. Describe the MTS services to be provided, including: outreach and engagement; medication administration, monitoring, and education; independent living skills; interactive therapies; health promotion and training, etc.
2. The program's policy and procedure for the development and implementation of the Brief Plan of Care, ITP, ITP review, screening assessment, face-to-face evaluation, and contact notes. Please include how and what will be reviewed/documented.
3. The organizational structure for staff including the provision of 24-hour on-call availability.
4. Description of compliance with the MTS staffing requirements (e.g., staffing ratio, hours for each of the multi-disciplinary team members, etc.)

ADDENDUM - F

Psychiatric Day Treatment Services
COMAR 10.21.02

Please submit the following information:

1. The program's plan for rendering psychiatric treatment including the identification of specific services (e.g., individual, group, and family therapy; psychopharmacological treatment; and activity, occupational, medical, and psychological treatment services).
2. Describe the populations to be served, including age groups and other relevant characteristics, and the number of the individuals that the program expects to serve.
3. Identify the program site(s), hours of operation, and the method to ensure that services are accessible to the individuals served.
4. The program's procedure for developing a mental status and physical exam.
5. The program's procedure for developing and implementing a treatment plan, including weekly treatment plan reviews with the psychiatrist.
6. A signed agreement for appropriate support services with a licensed general hospital or licensed psychiatric hospital.
7. A detailed staffing plan, including the RN and psychiatrist requirements.
8. The program's protocol for the use, monitoring, and/or administration of medications.
9. The program procedure for care and treatment during a psychiatric emergency.

ADDENDUM - G

**Group Home for Adults with Mental Illness
(GH)**

Please submit the following information:

1. Verification of compliance with the programmatic and staffing requirements of COMAR 10.21.21 and 10.21.22
2. Complete application for approval of a residence that includes documentation:
 - a. That the residence is owned or leased by the applicant
 - b. Of fire, liability and hazard insurance
 - c. That the residence was inspected by the CSA. Please include the certificate of general approval
 - d. The policies and procedures for the following
 1. Development of the managed intervention plan (MIP)
 2. Documentation of rehabilitation notes, promotion of illness management, significant events, incidents, etc.
 3. Medication Monitoring/administration and storage
 4. Background checks for staff

ADDENDUM - H

**Respite Care Services (RPCS)
COMAR 10.21.27**

Please submit the following information:

1. A detailed staffing plan which identifies the program's staffing ratio
2. A policy and procedure for medication monitoring of medications
3. The protocol for the development of the screening assessment and preliminary plan.
4. If the RPCS is to be provided in a residential setting for adults program, evidence of approval under COMAR 10.21.22.
5. If the RPCS is to be provided in a residential group home or Treatment Foster Care setting for youth, evidence of approval under COMAR 14.31.05 or 07.02.21.
6. Describe respite services to be provided and whether the services are in-house or out-of-home services

ADDENDUM - I

Therapeutic Nursery Programs (TNP) COMAR 10.21.18

Please submit the following information:

1. A plan for services (i.e. therapies, daily activities, services for families, orientation, etc.) that will be offered by staff that addresses the cultural and psychosocial development needs of the child. Submit a program design and give examples of some of the materials and teaching tools that will be used in the program.
2. A detailed staffing plan for the Therapeutic Nursery Program that satisfies the ratio established in regulation. (COMAR 10.21.18.08 E)
3. The program's protocol for the development of the developmental assessment, Individual Treatment Plan and contact, therapy & progress notes.
4. Identify any program linkages for referrals for a continuum of treatment.
5. A policy and procedure for referrals to services indicated in the ITP. See COMAR 10.21.10.06 (D)(2).
6. Protocols for health and safety (i.e. physical setting/maintenance, fire codes, child injury, etc.).
7. Evidence the program is approved as a Child Care Center

Addendum J

MENTAL HYGIENE ADMINISTRATION (MHA) REGULATED PROGRAMS BUSINESS PLAN INFORMATION SHEET

All applicants interested in obtaining program approval to provide mental health services in the Public Mental Health System must address the information requested below. It is mandatory that all questions be answered fully and accurately and the necessary identified documents be provided. The information requested is necessary in order to be approved as a Medicaid Provider and receive public funds. Your business plan must address the following issues and provide the necessary financial and other pertinent information requested within each category.

1. Please provide a budget for the first year of operations, which includes, at a minimum, the salary structure, client mix necessary to maintain financial stability and anticipated administrative/operational expenses.
2. Identify the source and amount of any start up funds. If applicable, provide a copy of the loan agreement or bank statement.
3. Provide a description of the program's financial reserves, as all services in the Public Mental Health System require authorization in advance before a claim is submitted. Please demonstrate your ability to pay in advance for all required staff and other essential expenses. It is necessary to clearly identify a plan to address delays in receipt of Medicaid payments.
4. Please provide proof of casualty insurance to cover emergency expenses. Also, provide a copy of the binder number, insurance company's name and phone number.
5. Provide a summary of the applicant's understanding of Medicaid reimbursement including the requirements for compliance with regulations, claims payment, and documentation.
6. To assist in expediting the processing and approval of your business plan, please identify the individual responsible for the completion of this business plan and his/her contact information.