

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION ONE: Program, Ownership and Emergency Contact Information

Ownership Information

Legal Name of Business/Owner: _____

*[“Owner” is defined as (a) “someone who owns (is legal possessor of) a business; (b) a proprietor.”
Certifications shall be issued in the legal name of the business/owner]*

Mailing Address of Business/Owner: _____

City or Town of Business/Owner: _____ **Zip Code:** _____

Business/Owner’s Web Site Address: _____

Business/Owner’s Email: _____

Business/Owner’s Phone Number: _____

Business/Owner’s Fax Number: _____

Type of Business Organization/Government Agency: _____

[“Business Organization” is defined as one of the six forms of business organizations for federal tax purposes.]

- | | | | |
|------------------------|--------------------------|-------------------------|--------------------------|
| i. Sole Proprietorship | <input type="checkbox"/> | vii. Government Agency: | <input type="checkbox"/> |
| ii. Corporation | <input type="checkbox"/> | City | <input type="checkbox"/> |
| iii. Partnership | <input type="checkbox"/> | State | <input type="checkbox"/> |
| iv. S-Corporation | <input type="checkbox"/> | Federal | <input type="checkbox"/> |
| v. Trust | <input type="checkbox"/> | | |
| vi. Non-Profit | <input type="checkbox"/> | | |

Program Information

Current Program or Trade Name: _____

[“Trade Name” is defined as “The name or style under which a concern does business.”]

Program Street Address: _____

Program Town or City: _____ **Zip Code:** _____

Program Web Site: _____

Program Email: _____

Program Phone Number: _____

Program Fax Number: _____

County of Operation: _____

National Provider Identification: _____

(If services are contracted with another State, Federal or Local government department, please attach a copy of the Contract Service Agreement to this application)

Emergency Contact (Must have access to Patient Records)

Emergency Contact Name: _____

[“Emergency Contact” is defined as: An individual who has access to patient records and can provide patient contact information at all times. (see COMAR 10.47.01.03D (1)(a)(i).]

Emergency Contact Home Address: _____

Emergency Contact City or Town: _____ **Zip Code:** _____

Emergency Contact’s Cell Phone: _____

Emergency Contact’s Office Phone: _____

Emergency Contact’s Home Phone: _____

Emergency Contact’s Email: _____

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION TWO: Certification Information

Current Certification Information:

The current certification number is: _____

[A "Current Certification Number" is defined as the registration or certification number issued to the program after the last survey and formally shown on the program's General Certificate of Approval issued by ADAA.]

The current certification for this Program expires on: _____

["Certification Expiration" is defined as the expiration date found on the program's General Certificate of Approval issued by ADAA.]

Not Applicable (please check)

["Not Applicable" would apply on applications for initial program applications, i.e., those programs that have not previously been issued a program certification number by ADAA.]

Type of Certification Requested on this Application.

Please Note: This application may be used for combinations of certification requests, e.g. a renewal application may also include a change in program location or an addition or deletion of service level. Please check all that apply. However, a separate application packet must be completed for each physical site.

Initial Certification Request (see COMAR 10.47.04.04A)

[An "Initial Certification" is defined as an application submitted by an owner for the first certification of a program that has never previously been certified by the ADAA. This certification is valid for a period not to exceed six months.]

Renewal of General Certification Request (see COMAR 10.47.04.04C)

[A "Renewal of General Certification" is defined as a certification which is provided to a currently certified program whose certification period is about to expire or has expired and the program is **not** requesting a change in program service level.]

Change of Program Location Certification Request (see COMAR 10.47.04.03G & 10.47.04.04D (6))

[A "Change of Program Location Certification" is defined as a request for certification of a program that has changed the physical location of its place of business, i.e. the site where the program provides its services to patients or a change in location of its administrative offices.]

Change in Service Levels Request (see COMAR 10.47.04.03D)

[A "Change in Service Levels" is defined as the addition or deletion of a program service level. (see COMAR 10.47.02.03 thru 10.47.02.11)]

Change in Program Ownership (See COMAR 10.47.04.03G)

[A "Change in Program Ownership" is defined any circumstances in which the ownership of the previously certified program is sold, transferred or reassigned.]

**Initial or Renewal Certification of Opioid Maintenance Therapy Program(s)
(see COMAR 10.47.02.11)**

(An application fee of \$700 is required with the initial application and at recertification, if the program provides opioid maintenance therapy (OTP). Checks shall be payable to DHMH/OHCQ)

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION THREE: CURRENT Patient Capacity and Service Levels

Current Service Level Certification (See COMAR 10.47.02.03 thru 10.47.02.11 & 10.47.03.03 thru 10.47.03.07. Please check all that apply and write under each category the # of adults, adolescents and/or children you serve.)

<u>Outpatient Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level 0.5 Early Intervention	_____	_____	_____
<input type="checkbox"/> Level 0.5 Early Intervention: DWI Ed	_____	_____	_____
<input type="checkbox"/> Level I – Outpatient	_____	_____	_____
<input type="checkbox"/> Level II.1 Intensive Outpatient	_____	_____	_____
<input type="checkbox"/> Level II.5 Partial Hospitalization	_____	_____	_____

<u>Residential Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level III.1 Clinically Managed Low Intensity Residential	_____	_____	_____
<input type="checkbox"/> Level III.3 Clinically Managed Medium Intensity Residential	_____	_____	_____
<input type="checkbox"/> Level III.5 Clinically Managed High Intensity Residential	_____	_____	_____
<input type="checkbox"/> Level III.7 Medically Monitored Intensive Inpatient Treatment	_____	_____	_____

<u>Detoxification Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level I.D Ambulatory Detoxification w/o Extended On-site Monitoring	_____	_____	_____
<input type="checkbox"/> Level II.D Ambulatory Detoxification with Extended On-site Monitoring.	_____	_____	_____
<input type="checkbox"/> Level III.2-D Clinically Managed Residential Detoxification	_____	_____	_____
<input type="checkbox"/> Level III.7-D Medically Monitored Inpatient Detoxification	_____	_____	_____

<u>Opioid Maintenance Therapy</u>	Adults	Adolescents
<input type="checkbox"/> OMT - Opioid Maintenance Therapy	_____	_____
<input type="checkbox"/> OMT.D – Only Opioid Maintenance Therapy Detoxification**	_____	_____

***(Check only if a State & Federally Approved Opioid Treatment Program)*

Correctional Service Levels (Select if a specific program requirement)

- Correctional Level I
- Correctional Level II.1
- Correctional Level II.5
- Correctional Level III.1
- Correctional Level III.5

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION FOUR: NEW Level Requests: Patient Capacity and Service Levels (Only complete if adding or changing levels)

New Service Level Certification Requests: (See COMAR 10.47.02.03 thru 10.47.02.11 & 10.47.03.03 thru 10.47.03.07. Please check all that apply and write under each category the # of adults, adolescents and/or children you want to serve.)

<u>Outpatient Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level 0.5 Early Intervention	_____	_____	_____
<input type="checkbox"/> Level 0.5 Early Intervention: DWI Ed	_____	_____	_____
<input type="checkbox"/> Level I – Outpatient	_____	_____	_____
<input type="checkbox"/> Level II.1 Intensive Outpatient	_____	_____	_____
<input type="checkbox"/> Level II.5 Partial Hospitalization	_____	_____	_____

<u>Residential Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level III.1 Clinically Managed Low Intensity Residential	_____	_____	_____
<input type="checkbox"/> Level III.3 Clinically Managed Medium Intensity Residential	_____	_____	_____
<input type="checkbox"/> Level III.5 Clinically Managed High Intensity Residential	_____	_____	_____

<u>Detoxification Services</u>	Adults	Adolescents	Children
<input type="checkbox"/> Level I.D Ambulatory Detoxification w/o Extended On-site Monitoring	_____	_____	_____
<input type="checkbox"/> Level II.D Ambulatory Detoxification with Extended On-site Monitoring.	_____	_____	_____
<input type="checkbox"/> Level III.2-D Clinically Managed Residential Detoxification	_____	_____	_____
<input type="checkbox"/> Level III.7-D Medically Monitored Inpatient Detoxification	_____	_____	_____

<u>Opioid Maintenance Therapy</u>	Adults	Adolescents
<input type="checkbox"/> OMT - Opioid Maintenance Therapy	_____	_____
<input type="checkbox"/> OMT.D –ONLY Opioid Maintenance Therapy Detoxification** **(Check only if a State & Federally Approved Opioid Treatment Program)	_____	_____

<u>Correctional Service Levels</u> (Select if a specific program requirement)
<input type="checkbox"/> Correctional Level I
<input type="checkbox"/> Correctional Level II.1
<input type="checkbox"/> Correctional Level II.5
<input type="checkbox"/> Correctional Level III.1
<input type="checkbox"/> Correctional Level III.5

This program will provide services in the following treatment settings: (Please check all that apply)

<input type="checkbox"/> Maryland Division of Correction	<input type="checkbox"/> Local Detention Center
--	---

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION FIVE: Staffing Information

Staffing Information: *Please provide the listed information (as required by COMAR 10.47.01.06) for these required staff positions.*

Sponsor (Information required for OTP only - 42 CFR Part 8.2)

Name of Sponsor: _____
Mailing Address of Sponsor: _____
City or Town of Sponsor: _____
Sponsor's E-mail Address: _____
Sponsor's Phone Number: _____

Program Administrator (COMAR 10.47.01.06A)

Program Administrator's Name: _____

A current resume and/or curricula vitae.

Copies of required credentials, e.g., Bachelor's Degree or evidence of five years experience in human services. *(Please note that these credentials shall accompany the program's application only at the time of the Initial Certification request and on submission of an application for Renewal of General Certification when there has been a change in the individual assigned duties as Program Administrator. If the individual serving as Program Administrator has not changed repeated submittals of credentials are not required or necessary.)*

Medical Director, if required (see COMAR 10.47 and CFR 42 parts 2 & 8)

Medical Director's Name: _____

A current resume and/or a curricula vitae.

Copies of required credentials, e.g., a current medical license. *(Please note that these credentials shall accompany the program's application only at the time of the Initial Certification request and on submission of an application for Renewal of General Certification when there has been a change in the individual assigned duties as Medical Director. If the individual serving as Medical Director has not changed repeated submittals of credentials are not required or necessary.)*

For Opioid Maintenance Therapy programs only: The Medical Director's resume must document 3 years experience providing services to persons who are addicted to alcohol or other drugs, including at least 1 year experience in the treatment of opioid addiction with opioid maintenance therapy in addition to at least one of the required criteria listed at COMAR 10.47.02.11C(2) (i – iv.)

Clinical Supervisor (see COMAR 10.47.01.06C & 10.47.01.02B(15))

Clinical Supervisor's Name: _____

Supervisory Approval letter from the Board of Professional Counselors and Therapists (if applicable) *(Please note these credentials shall accompany the program's application only at the time of the Initial Certification request and on submission of an application for Renewal of General Certification when there has been a change in the individual assigned duties as Clinical Supervisor. If the individual serving as Clinical Supervisor has not changed repeated submittals of credentials are not required or necessary.)*

Clinical Staff (see COMAR 10.47.01.06D & 10.47.01.02B(15)).

- A roster of the names and job titles of the clinical and nursing staff, as well as the registered dietician and food service manager, employed at the time of the application.

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION SIX: General Supporting Documentation

Please provide with this application the following supporting documentation:

Governing Body

A roster of the member or members of the program’s governing body as required by COMAR 10.47.01.03. The roster shall have the name and mailing address of all members.

(A “Governing Body” means the organizational structure that is responsible for establishing policy, maintaining quality care, and providing management and planning for the program.

Organizational Chart

The 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.

Local Government Approvals

- **Copy of a Zoning Use approval form/letter and /or a Certificate of Occupancy (C of O) from the jurisdiction in which the program is located.** *(The Zoning Use Approval and/or a C of O shall be submitted only with an application for Initial Certification or with an application for Change of Program Location Certification.)*
- **A copy of the current Fire Inspection Report.**
- **For residential programs providing dietary services the application shall include evidence of compliance with the local health department, sanitarian etc.**
- **A copy of the Maryland Division of Drug Control Application.**

For Opioid Maintenance Therapy programs only:

- **A copy of the program’s SAMHSA application (SMA 162) and/or a SAMHSA acknowledgement letter or letter of intent shall accompany the program’s request for Initial Certification.**
- **A copy of the Department of Justice/ Drug Enforcement Agency’s Diversion Enforcement Application.**
- **A copy of the Maryland Division of Drug Control Application**

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION SEVEN: Required Statistics

Statistics Required

The number of patients receiving services at the time of the application: _____
(The "number of patients receiving services" is defined as the TOTAL number of patients receiving program services on the day the application is submitted to OHCQ irrespective of the type of services those patients are receiving. An application, for example, requesting an Initial Certification would have a patient census of zero at the time of the application submittal.)

This program will provide the following language/communication services (Please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Other Language service: _____ |
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Services for the Hearing Impaired |

This program will serve:

- Adult Males
- Adult Females
- Women with Children
- Pregnant Woman
- Adolescents (12-17 years of age)

This program will receive public funds from the following sources (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Start Up Funds |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Federal Funds |
| <input type="checkbox"/> Medical Assistance | <input type="checkbox"/> Local Government Funds |

(Please note: If any of the above funding sources are checked please contact ADAA to determine reporting requirements!)

Mental Health (Check only one)

- Co-Occurring Enhanced (refer to the American Society of Addiction Medicine-Patient Placement Criteria)
- Co-Occurring Capable (Refer to ASAM-PC)

APPLICATION FOR ALCOHOL AND DRUG ABUSE PROGRAM CERTIFICATION

SECTION EIGHT: AFFIRMATION

Has any disciplinary action against any governing body members, any management personnel, clinical staff, or support staff been taken by any Federal, State or local government entity that mandates that a particular staff person cannot be associated with patient care in any health care setting? YES NO

If the answer to this question is "yes" please explain the circumstances of the finding, the nature of the offense and the current status of the action on the lines above. If additional space is needed, use the document entitled "AFFIRMATION (continuation page)" attached to this application. If the answer to this question is "no" there is no further action required.

Has any Board member or member of the owner's staff or program's management staff been associated with any health care provider which has been disciplined to the extent that they are no longer allowed to provide health care services? YES NO

If the answer to this question is "yes" please explain the circumstances of the finding, the nature of the offense and the current status of the action on the lines above. If additional space is needed, use the document entitled "AFFIRMATION (continuation page)" attached to this application. If the answer to this question is "no" there is no further action required.

My signature below affirms the following:

I affirm under penalty of perjury that this application and all supporting documentation have been developed and approved by the governing body.

I affirm under penalty of perjury that the information contained in this application and the supporting documentation is true and accurate to the best of my personal knowledge and belief.

It is understood by the undersigned that any inaccuracies, falsehoods or fraudulent representations in this application shall constitute grounds for revocation of certification.

Program Administrator's Name (print): _____

Program Administrator's Signature: _____

Date: _____

