STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center ● Bland Bryant Building
55 Wade Avenue ● Catonsville, Maryland 21228-4663
Martin O'Malley, Governor –Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

APPLICATION PACKET
COMAR 10.47- ALCOHOL AND DRUG ABUSE ADMINISTRATION

All sections, along with required documentation, are to be completed and returned to the OHCQ - Substance Abuse Unit at the following address:

Office of Health Care Quality
Substance Abuse Certification Unit
Bland Bryant Building – Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228

Please read and familiarize yourself with **COMAR 10.47.Alcohol and Drug Abuse Administration, dated August 2008,** prior to completing this application.

Please direct inquiries concerning this application and the application process to the Substance Abuse Certification Unit:

Substance Abuse Unit – (410) 402-8095

Thank you for your attention to these matters.

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.]

Business Organization	Government Agency Type
☐ I. Sole Proprietorship	☐ VII. Government Agency
☐ II. **Corporation	☐ a) City
☐ III. Partnership	☐ b) State
☐ IV. S-Corporation	☐ c) Federal
☐ V. Trust	
☐ VI. **Non-Profit	

** Non-Profit Corporation requires submission of IRS Form 990

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:

__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 (Opioid Maintenance Therapy Programs). Checks shall be payable to DHMH/OHCQ.

<u>C U R R E N T</u> 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**.

Outpatient Services

	Adults	Adolescents	Children
☐ Level 0.5 Early Intervention			
☐ Level 0.5 Early Intervention: DWI Ed			
☐ Level I – Outpatient			
☐ Level II.1 Intensive Outpatient			
☐ Level II.5 Partial Hospitalization			

Residential Services

	Adults	Adolescents	Children
☐ Level III.1 Clinically Managed Low Intensity Residential			
☐ Level III.3 Clinically Managed Medium Intensity			
☐ Level III.5 Clinically Managed High Intensity Residential			
☐ Level III.7 Medically Monitored Intensive Inpatient Treatment			

Detoxification Services

	Adults	Adolescents	Children
☐ Level I.D Ambulatory Detoxification w/o Extended On-site Monitoring			
☐ Level II.D Ambulatory Detoxification with Extended On-site Monitoring			
☐ Level III.2-D Clinically Managed Residential Detoxification			
☐ Level III.7-D Medically Monitored Inpatient Detoxification			

Opioid Maintenance Therapy

	Adults	Adolescents
☐ OMT - Opioid Maintenance Therapy		
☐ **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

NEW Level Requests

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 to be served**.)

Outpatient Services

	Adults	Adolescents	Children
☐ Level 0.5 Early Intervention			
☐ Level 0.5 Early Intervention: DWI Ed			
☐ Level I – Outpatient			
☐ Level II.1 Intensive Outpatient			
☐ Level II.5 Partial Hospitalization			

Residential Services

	Adults	Adolescents	Children
☐ Level III.1 Clinically Managed Low Intensity Residential			
☐ Level III.3 Clinically Managed Medium Intensity Residential			
☐ Level III.5 Clinically Managed High Intensity Residential			

Detoxification Services

	Adults	Adolescents	Children
☐ Level I.D Ambulatory Detoxification w/o Extended On-site Monitoring			
☐ Level II.D Ambulatory Detoxification with Extended On-site Monitoring			
☐ Level III.2-D Clinically Managed Residential Detoxification			
☐ Level III.7-D Medically Monitored Inpatient Detoxification			

Opioid Maintenance Therapy

	Adults	Adolescents
☐ OMT - Opioid Maintenance Therapy		
☐ **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

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

☐ Maryland Division of Correction   ☐ Local Detention Center

Staffing Information

Please Provide The Listed Information (As Required By COMAR 10.47.01.06) For These Required Staff Positions.

Sponsor

Information required for Opioid Maintenance Therapy Programs 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

Program Administrator's Name:

Medical Director's Name:

Clinical Supervisor's Name:

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.

Required Statistics

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

☐	Spanish	☐	Services for the Hearing Impaired
☐	American Sign Language	☐	Other Language service(s):

This Program Will Serve

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

This program will receive public funds from the following sources
Please Check all that Apply

☐	Medicaid	☐	Start Up Funds
☐	Medicare	☐	Federal Funds
☐	Medical Assistance	☐	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)*