



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

APPLICATION FOR LICENSURE UNDER
COMAR 10.63 COMMUNITY-BASED
BEHAVIORAL HEALTH PROGRAMS AND SERVICES

DHMH #4780 (October 1, 2016)

IMPORTANT: PLEASE READ INSTRUCTIONS BEFORE COMPLETING APPLICATION

This application packet should be used by applicants/programs that are seeking licensure under COMAR Title 10, Subtitle 63 Community-Based Behavioral Health Programs and Services. Before applying for licensure under COMAR 10.63, a program shall enter into an agreement to cooperate with the core service agency (CSA), local addictions authority (LAA), or local behavioral health authority (LBHA) that operates in the relevant county or Baltimore City. A copy of the signed agreement must accompany this application. For a copy of the Agreement to Cooperate, please go to <http://bha.dhmh.maryland.gov/Pages/Forms.aspx>.

Please fill in the requested information completely. If this application is incomplete or missing any of the documentation required, the processing of the application will stop and the application will be returned to the applicant to provide the missing information (*COMAR 10.63.06.02B*). Please note that **each program site** requires a separate application (except for residential rehabilitation program sites with three or fewer beds).

All complete applications are reviewed in the order that they are received. This is the most equitable way to prioritize the application review process. Due to the number of applications received, there may be a wait period before your application can be reviewed. We do appreciate your understanding.

Please read and familiarize yourself with the most current regulation chapters - **COMAR 10.63 Community-Based Behavioral Health Programs and Services**. If you need a copy of the regulations, please contact the Division of State Documents at (410) 974-2486 or Toll Free at (800) 633-9657, or go to the following web address to download the order form: <http://www.dsd.state.md.us/PDF/DHMHBooklets.pdf>. When completing the form to request COMAR booklets, **return that form and payment to: Office of the Secretary of State Division of State Documents • State House • Annapolis, MD 21401 Tel: 410-260-3876 • 800-633-9657 • Fax: 410-280-5647**. If you want to review the regulations on-line, please go to: <http://www.dsd.state.md.us/COMAR/ComarHome.html> and follow the instructions.

Please Return Completed Application to: Stacey Diehl, Program Manager
Behavioral Health Unit
Office of Health Care Quality
Spring Grove Hospital Center
Bland Bryant Building • 55 Wade Avenue
Catonsville, MD 21228

Should you have any questions about this application form, please contact the OHCQ Behavioral Health Unit at (410) 402.8198.

1) PROVIDER INFORMATION: The corporate/business name of the provider/program must match what is registered with the Maryland Department of Assessments and Taxation (SDAT). If something doesn't apply to you, mark "NA". If "NA" is marked, you may be asked to provide a reason the section doesn't apply to you, if the reason is not obvious.

Corporate/Business Name:		
Corporate Address:		County:
Corporate Website:		
Owner Last Name:	First Name:	
Primary Contact:	Phone: () -	Title:
Primary Contact Email: @	Fax: () -	

Trade Name:		
Website (if different from Corporate Website):		
Program Address:		County:
Primary Contact:	Phone: () -	Title:
Primary Contact Email:	Fax: () -	

2) CORRESPONDENCE ADDRESS INFORMATION: In the event that correspondence must be sent via the United States Postal Service, enter the Correspondence Address to which you want all your correspondence mailed. Please note that, when possible, communications will be sent via email.

- Corporate Name/Address
- Trade Name & Address
- Other:

Street Address: City: State: Zip:

Preferred Email Address: @

3) APPLICATION TYPE: Please check all program and/or service types that apply. Program/service types marked with an (*) do not require accreditation in order to receive a license for that particular program/service type (COMAR 10.63.05.03). All other program/service types require accreditation in order to receive a license (COMAR 10.63.02.02). "Capacity" means the total number of individuals that a program can accommodate.

	Capacity			
	# Beds	# Adults	# Adolescents	# Children
<input type="checkbox"/> DUI Education Program (COMAR 10.63.05.05)*				
<input type="checkbox"/> Early Intervention Level 0.5 Program (COMAR 10.63.05.06)*				
<input type="checkbox"/> Group Homes for Adults with Mental Illness (COMAR 10.63.04.03)				
<input type="checkbox"/> Integrated Behavioral Health Program (COMAR 10.63.03.02)				
<input type="checkbox"/> Intensive Outpatient Treatment Level 2.1 Program (COMAR 10.63.03.03)				
<input type="checkbox"/> Mobile Treatment Services Program (MTS) (COMAR 10.63.03.04)				
<input type="checkbox"/> Opioid Treatment Services (COMAR 10.63.03.19)				
<input type="checkbox"/> Outpatient Mental Health Center (OMHC) (COMAR 10.63.03.05)				
<input type="checkbox"/> Outpatient Treatment Level 1 Program (COMAR 10.63.03.06)				
<input type="checkbox"/> Partial Hospitalization Treatment Level 2.5 Program (COMAR 10.63.03.07)				
<input type="checkbox"/> Psychiatric Day Treatment Program (PDTP) (COMAR 10.63.03.08)				
<input type="checkbox"/> Psychiatric Rehabilitation Program for Adults (PRP-A) (COMAR 10.63.03.09)				
<input type="checkbox"/> Psychiatric Rehabilitation Program for Minors (PRP-M) (COMAR 10.63.03.10)				
<input type="checkbox"/> Residential Crisis Services Program (RCS) (COMAR 10.63.04.04)				
<input type="checkbox"/> Residential- Low Intensity Level 3.1 Program (COMAR 10.63.03.11)				
<input type="checkbox"/> Residential- Medium Intensity Level 3.3 Program (COMAR 10.63.03.12)				

3) Application Type: *Continued*

	Capacity			
	# Beds	# Adults	# Adolescents	# Children
<input type="checkbox"/> Residential-High Intensity Level 3.5 Program (COMAR 10.63.03.13)				
<input type="checkbox"/> Residential-Intensive Inpatient Level 3.7 Program (COMAR 10.63.03.14)(Requires Certificate of Need)				
<input type="checkbox"/> Residential Rehabilitation Program (RRP) (COMAR 10.63.04.05)				
<input type="checkbox"/> Respite Care Services Program (RPCS) (COMAR 10.63.03.15)				
<input type="checkbox"/> Substance-Related Disorder Assessment and Referral Program (COMAR 10.63.05.14)*				
<input type="checkbox"/> Supported Employment Program (SEP) (COMAR 10.63.03.16)				
<input type="checkbox"/> Withdrawal Management Service (COMAR 10.63.03.18)				

4) ACCREDITATION INFORMATION: If you are applying for an accreditation-based license under COMAR Title 10, Subtitle 63, please check the appropriate accreditation organization. You must provide a copy of the most recent behavioral health accreditation survey report, a copy of any corrective action plans required by the behavioral health accreditation organization survey report of the program, and a copy of the final letter or certificate issuing accreditation for the program.

- Accreditation Commission for Health Care (ACHC) – Effective Dates: From To
- Council on Accreditation (COA) – Effective Dates: From To
- Council on Accreditation of Rehabilitation Facilities (CARF) – Effective Dates: From To
- The Joint Commission (TJC) – Effective Dates: From To

5) ATTESTATION THAT PROGRAM COMPLIES WITH SPECIFIC PROGRAM & SERVICE DESCRIPTION(S).

I, Insert Name am affirming that Insert Corporate/Business Name is in compliance and will remain in compliance with all applicable regulations, including any and all program/service descriptions, specific staffing requirements and appropriate staff credentials as they relate to the program(s)/service(s) identified in Section 3 of this application.

(Signature)

(Date)

6) ATTESTATION(S) FOR SPECIFIC PROGRAM STAFF. Please check all relevant staff positions listed below.
Staff who hold the specific position must sign the affidavit.



Outpatient Mental Health Center (OMHC) (COMAR 10.63.03.05C)

An OMHC shall employ a medical director, who:

- (1) Is a psychiatrist (***attach copy of applicable credential***);
- (2) Has over-all responsibility for clinical services; and
- (3) Is on-site at least 20 hours per week.

Affidavit:

I, Insert Name, M.D., Maryland License Number Insert License #, under the penalties of perjury, acknowledge that I am the medical director of Insert Corporate/Business Name effective Insert Date. I specifically acknowledge that I am a psychiatrist, have overall responsibility for clinical services, and am on-site at the OMHC at least 20 hours per week.

(Signature)

(Date)



Psychiatric Rehabilitation Program for Adults (PRP-A) (COMAR 10.63.03.09C&D)

A PRP-A shall be under the direction of a rehabilitation specialist who is:

- 1. A licensed mental health professional; certified by the Commission on Rehabilitation; Counselor Certification; or certified by the Psychiatric Rehabilitation Association (***attach copy of applicable credential***); and
- 2. Employed at least 20 hours per week when the program serves less than 30 individuals; or 40 hours per week when the program serves 30 individuals or more.

Affidavit:

I, Insert Name, under the penalties of perjury, acknowledge that I am the rehabilitation specialist for Insert Program Name PRP-A, effective Insert Date, which serves Insert # number of individuals per week. I specifically acknowledge that I have overall responsibility for the direction of rehabilitation services, and am employed at the PRP-A at least Insert # Hours hours per week.

(Signature)

(Date)



Psychiatric Rehabilitation Program for Minors (PRP-M) (COMAR 10.63.03.10B&C)

A PRP-M shall be under the direction of a rehabilitation specialist who:

1. Has a minimum of 2 years direct care experience working with youth with a serious emotional disorder;
2. Is a licensed mental health professional; or certified by the Psychiatric Rehabilitation Association and has obtained the Psychiatric Rehabilitation Association Children’s Psychiatric Rehabilitation Certificate **(attach copy of applicable credential)**; and
3. Is employed at least 20 hours per week when the program serves less than 30 individuals or at least 40 hours per week when the program serves 30 individuals or more.

Affidavit:

I, Insert Name, under the penalties of perjury, acknowledge that I am the rehabilitation specialist for Insert Program Name PRP-M, effective Insert Date, which serves Insert # number of individuals per week. I specifically acknowledge that I have a minimum of 2 years direct care experience working with youth with a serious emotional disorder; have overall responsibility for the direction of rehabilitation services, and am employed at the PRP-M at least Insert # Hours hours per week.

(Signature)

(Date)



Opioid Treatment Service (COMAR 10.63.03.19)

The opioid treatment service is one that is under the direction of a medical director who is a physician and:

1. Has at least 3 years of documented experience providing services to persons with substance-related disorders and opioid use disorders, including at least 1 year of experience in the treatment of opioid use disorder with opioid maintenance therapy and is board-certified in addiction medicine or addiction psychiatry **(attach copy of applicable credential)** ; or
2. Is certified in added qualifications in addiction psychiatry by the American Board of Psychiatry and Neurology, Inc. **(attach copy of applicable credential)**.

Affidavit:

I, Insert Name, M.D. (print), Maryland License Number Insert #, under the penalties of perjury, acknowledge that I am the medical director of Insert Program Name opioid treatment service effective Insert Date. I

specifically acknowledge that I am board-certified in addiction medicine, addiction psychiatry, or certified in added qualifications in addiction psychiatry by the American Board of Psychiatry and Neurology, Inc.

(Signature)

(Date)

7) ATTESTATION OF COMPLIANCE WITH RELEVANT FEDERAL, STATE, OR LOCAL ORDINANCES, LAWS, REGULATIONS, AND ORDERS GOVERNING THE PROGRAM.

I, Insert Name, am affirming that Insert Corporate/Business Name shall comply with all applicable federal, state and local ordinances, laws, regulations, transmittals, guidelines, orders, administrative service organization provider alerts and provider manual instructions governing the program.

(Signature)

(Date)

8) REQUIRED DISCLOSURES (check all that apply and provide all documentation supporting or demonstrating the information disclosed):

YES **NO** (check one for each of the following)

- Has there been a revocation of a license, certificate, or approval issued within the previous 10 years from any in-State or out-of-State provider previously or currently associated with the applicant;
- Has the applicant, a program, corporation or provider previously or currently associated with the applicant, surrendered or defaulted on its license, certificate, or approval for reasons related to disciplinary action, within the previous 10 years;
- Has any individual who has served as a corporate officer for the provider who has had a license, certificate, or approval revoked, or has surrendered or defaulted on an approval, license, certificate, or approval, for reasons related to disciplinary action, within the previous 10 years. If check, please provide the name of that individual: Insert Name
- Has the applicant, owner, program director, or other staff of the applicant had any criminal conviction(s)?

Affidavit:

I, Insert Name, am affirming that the above statements are true.

(Signature)

(Date)

9) REQUIRED SUPPLEMENTAL INFORMATION/DOCUMENTS. Please submit with this application, a copy of the following documents and answer any additional questions. If any required document is missing, this application will not be processed and will be returned to the applicant.

FOR ALL APPLICANTS:

- Copy of the Agreement to Cooperate between the program and the CSA, LAA, or LBHA, as appropriate;
- Copies of all applicable permits required by local jurisdictions, including:
 - Fire Inspection Report/Permit
 - Use and Occupancy Permit
- Copy of the program’s policy on criminal background investigation (*COMAR 10.63.01.05C*)
- Copy of all documentation supporting or demonstrating the information disclosed under Section 8
- Copy of documented proof of the program’s good standing status with SDAT



FOR ACCREDITATION-BASED LICENSE APPLICANTS:

- Copy of the most recent behavioral health accreditation survey report, if applying for an accreditation-based license;
- Copy of any corrective action plans required by the behavioral health accreditation organization survey report of the program; and
- Copy of the final letter or certificate issuing accreditation for the program.



FOR NON-ACCREDITATION BASED LICENSE APPLICANTS:

- Copy of the program’s grievance policy (*COMAR 10.63.05.07C*)

Is your facility ready for an on-site inspection at the time of application? Yes No

If you answered “No”, what is the anticipated date that site will be ready for inspection: Insert Date

NOTE: *Should not be more than 6 months from date of application submission.*

FOR NON-ACCREDITATION BASED LICENSE APPLICANTS - *Continued*

Hours of Operation	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	to	to	to	to	to	to	to



FOR RESIDENTIAL REHABILITATION PROGRAMS:

- Copy of the **CSA or LBHA** (whichever is appropriate) annual site inspection report/certificate (*COMAR 10.63.04.05J*)
- Total number of Beds: Insert #
- Copy of the program’s policy regarding the managed intervention plan (*COMAR 10.63.04.05K*)



FOR RESIDENTIAL-INTENSIVE INPATIENT LEVEL 3.7 PROGRAMS:

- Copy of Certificate of Need (CON)

10) AUTHORIZATION: I, Insert Name, the practitioner, administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief.

Date:

Signature of Practitioner, Administrator or Authorized Professional Responsible for the

Quality of Patient Care: _____