STATE OF MARYLAND
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH ADMINISTRATION

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

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) for each jurisdiction in which the program proposes to operate. A copy of the agreement(s), signed by the appropriate CSA, LAA, or LBHA, must accompany this application. The CSA, LAA, or LBHA will need a copy of page 2, all applicable pages 3-4 of this application, and proof of accreditation, if applicable, as part of the process of signing the agreement. For a copy of the Agreement to Cooperate, please go to https://bha.health.maryland.gov/Pages/newforms.aspx.

This is a fillable document, which means that you may complete it electronically. You must then print it out, sign where indicated and appropriate, and then submit it along with all required supplemental materials.

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 **Section 3 of the application is required for each program site** (except for residential rehabilitation program sites with three or fewer beds).

All complete applications are reviewed in the order that they are received. INTENTIONAL FALSE OR MISLEADING INFORMATION WILL RESULT IN DENIAL OF APPLICATION AND MAY LEAD TO INABILITY TO SEEK LICENSURE.

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 electronically to: **bha.licensing@maryland.gov. Please submit application and attachments as separate PDF documents. Incomplete applications will be returned. IN-PERSON DELIVERY OF DOCUMENTS WILL NOT BE ACCEPTED.**

Should you have any questions about this application form or are unable to submit your application electronically, please contact the Behavioral Health Licensing Unit at bha.licensing@maryland.gov.

---

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 (City, State, Zip)**:**		**County:**
Corporate Website:		
Trade Name (if different from Corporate Name)**:**		
Website (if different from Corporate Website)**:**		
Owner Last Name:	**First Name:**	
Primary Contact:	**Phone:** ( ) -	**Title:**
Primary Contact Email: @	**Fax:** ( ) -	
Published Agency Email: @	**Published Agency Phone:** ( ) -	

2) The name and social security number or tax identification of any individual or entity with a 5% or more interest in the Provider/Program. (Attach an additional page if necessary)

Name	**SS or Tax ID**	**% ownership**
a.		
b.		
c.		

3) 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
☐ Other:
Street Address: City: State: Zip:

4) Licensed Site Location Information (This section must be completed for **each physical site**, except for residential rehabilitation program sites with three or fewer beds).

Name of Site (Optional)

Street Address of program site:

_____
_____
County/City _____ **Zip**_____

At this Program location,

a) Does the Organization: ☐ OWN or ☐ RENT/LEASE. If Rent/Lease, include copy of lease.

b) Does the Organization share any space, including but not limited to, conference rooms, lobby, kitchen with any other program or entity? ☐ Yes ☐ No If yes, with whom:_____

c) Does the Program share employees/staff/services with any other Program/entity, including shared receptionist? If yes, with whom:_____

5) APPLICATION TYPE: Please check all program and/or service types applied for at this location. 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)*.

For Residential Services, "capacity" means the total number of beds. For Outpatient Services, capacity means the total number of separate individuals projected to receive services in a given week.

	Capacity			
	# Beds	**# Adults**	**# Adolescents**	**# Children**
☐ DUI Education Program *(COMAR 10.63.05.05)**				
☐ Early Intervention Level 0.5 Program *(COMAR 10.63.05.06)**				
☐ Group Homes for Adults with Mental Illness *(COMAR 10.63.04.03)*				
☐ Integrated Behavioral Health Program *(COMAR 10.63.03.02)*				
☐ Intensive Outpatient Treatment Level 2.1 Program *(COMAR 10.63.03.03)*				
☐ Mobile Treatment Services Program (MTS) *(COMAR 10.63.03.04)*				
☐ Opioid Treatment Services *(COMAR 10.63.03.19)*				
☐ Outpatient Mental Health Center (OMHC) *(COMAR 10.63.03.05)*				
☐ Outpatient Treatment Level 1 Program *(COMAR 10.63.03.06)*				
☐ Partial Hospitalization Treatment Level 2.5 Program *(COMAR 10.63.03.07)*				
☐ Psychiatric Day Treatment Program (PDTP) *(COMAR 10.63.03.08)*				
☐ Psychiatric Rehabilitation Program for Adults (PRP-A) *(COMAR 10.63.03.09)*				

☐ Psychiatric Rehabilitation Program for Minors (PRP-M) *(COMAR 10.63.03.10)*				
☐ Residential Crisis Services Program (RCS) *(COMAR 10.63.04.04)*				
☐ Residential - Low Intensity Level 3.1 Program *(COMAR 10.63.03.11)*				
☐ Residential - Medium Intensity Level 3.3 Program *(COMAR 10.63.03.12)*				
☐ Residential - High Intensity Level 3.5 Program *(COMAR 10.63.03.13)*				
☐ Residential - Intensive Inpatient Level 3.7 Program *(COMAR 10.63.03.14)(Requires Certificate of Need)*				
☐ Residential Rehabilitation Program (RRP) *(COMAR 10.63.04.05)*				
☐ Respite Care Services Program (RPCS) *(COMAR 10.63.03.15)*				
☐ Substance-Related Disorder Assessment and Referral Program *(COMAR 10.63.05.14)**				
☐ Supported Employment Program (SEP) *(COMAR 10.63.03.16)*				
☐ Withdrawal Management Service *(COMAR 10.63.03.18)*				

6) 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 of owner or controlling partner/CEO) (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) ATTESTATION OF COMPLIANCE WITH COMAR 10.01.18, SEXUAL ABUSE AWARENESS AND PREVENTION TRAINING (required for publicly-funded psychiatric rehabilitation programs for adults and minors, residential rehabilitation programs, and supported employment programs.)

I, Insert Name, am affirming that Insert Corporate/Business Name shall comply with COMAR 10.01.18, Sexual Abuse Awareness and Prevention Training.

_____ _____

(Signature) (Date)

9) ATTESTATION(S) FOR SPECIFIC PROGRAM STAFF. Please check all relevant staff positions listed below. Staff who hold the specific position must sign the affidavit. (For agencies with multiple sites, additional signature lines are provided for instances in which more than one individual functions in the role and when each individual meets all the regulatory requirements that are listed.)

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

An OMHC shall employ a medical director, who:
(1) Is a psychiatrist or psychiatric nurse practitioner ***(attach copy of applicable credential)***;
(2) Has overall responsibility for clinical services; and
(3) Is on-site or providing clinical oversight via HIPAA compliant telehealth at least 20 hours per week.

Affidavit:

Under the penalties of perjury, acknowledge that I am the medical director of Insert Corporate/Business Name. I specifically acknowledge that I am a psychiatrist/ psychiatric nurse practitioner, have overall responsibility for clinical services, and am on-site or providing clinical oversight via HIPAA compliant telehealth at the OMHC at least 20 hours per week. List all current employers (including contractual positions), position, and number of hours employed:

_____

____

____

Insert Name, Maryland License Number Insert License #, effective Insert Date

______________________________________ _________________
(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. Hours worked must coincide with the normal operating hours of the Program.

Affidavit:

Under the penalties of perjury, acknowledge that I am the rehabilitation specialist for Insert Program Name PRP-A, 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 for the amount of time required according to the provisions of COMAR 10.63.03.09D. **I have listed all the programs where I currently work, including contractual positions.**

Insert Name, effective Insert Date, employed Insert # Hours hours per week. Other employers, position, and hours:

____

____

____

______________________________________ _________________
(Signature) (Date)

Insert Name, effective Insert Date, employed Insert # Hours hours per week. Other employers, position, and hours:

____

____

____________________________________ ________________

(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. Hours worked must coincide with the normal operating hours of the Program.

Affidavit:

Under the penalties of perjury, acknowledge that I am the rehabilitation specialist for Insert Program Name PRP-M, 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 for the amount of time required according to the provisions of COMAR 10.63.03.10C . I have included all the programs where I currently work, including in a contractual position.

Insert Name, effective Insert Date, employed Insert # Hours hours per week. Other employers, position, and hours:

____

____

____________________________________ ____________________________________

(Signature) (Date)

Insert Name, effective Insert Date, employed Insert # Hours hours per week. Other employers, position, and hours:

____

____

____ _______________________________________

(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:

Under the penalties of perjury, acknowledge that I am the medical director of Insert Program Name opioid treatment service. 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.

Insert Name, M.D. (print), Maryland License Number Insert #, effective Insert Date

____ ___________________

(Signature) (Date)

●●

Withdrawal Management Service *(COMAR 10.63.03.18)*

A. Will the withdrawal management service require:
   1. ☐ the dispensing of methadone,
   2. ☐ the prescribing/dispensing of buphrenorphine/suboxone or similar medication?

B. If methadone: Is the program licensed as an OTP? How will methadone be acquired?

   ____

   ____

C. If buphrenorphine/suboxone: name and license number of Data Waiver clinician(s)

   ____

   ____

10) 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 or any individual or entity with 5% or more ownership of the program, 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 "Yes" is checked, please provide the name of that individual: Insert Name

☐ ☐ Is there any conflict of interest between the provider and any individual potentially receiving services?

Affidavit:

I, Insert Name, am affirming that the above statements are true. I affirm that I have legal authority to sign for the provider and bound the provider to any legal obligations.

_____ _____

(Signature) (Date)

11) 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. **PLEASE NOTE: Applicants currently on an extension from an accreditation organization are not eligible to apply under COMAR 10.63 until the accreditation has been formally renewed and there are beginning and end effective dates**.

☐ 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
☐ The National Commission on Correctional Health Care (NCCHC) – **Effective Dates:** From To

---

12) CHECKLIST OF 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 signed Agreement to Cooperate between the program and the CSA, LAA, or LBHA, for each jurisdiction (County/Baltimore City) in which the program proposes to operate. (Please note, the BHA Licensing Unit is not responsible for obtaining the signature from the CSA, LAA, or LBHA – that is the responsibility of the applicant);
☐ Copies of the:
  ☐ Fire Inspection Report/Permit
  ☐ Use and Occupancy Permit (if applicable)
☐ 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 10 of this Application
☐ Copy of documented proof of the program's good standing status with SDAT
☐ Copy of organizational chart showing all management and supervisory positions
☐ Copy of rental agreement if leasing program location

●●

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 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)
Attach documentation of any bed day capacity requirements imposed by the Maryland Health Care Commission.

●●

FOR NON-ACCREDITATION BASED LICENSE APPLICANTS:

☐ Copy of the program's grievance policy *(COMAR 10.63.05.07C)*

☐ Copy of the program's DUI Curriculum, if providing DUI education services *(COMAR 10.63.05.05)*

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.*

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

---

13) 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: ____