STATE OF MARYLAND
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH ADMINISTRATION

APPLICATION FOR LICENSURE UNDER COMAR 10.63

IMPORTANT: PLEASE READ INSTRUCTIONS BEFORE COMPLETING APPLICATION

This application packet is for use by applicants/programs seeking licensure under COMAR Title 10, Subtitle 63 Community-Based Behavioral Health Programs and Services. All license applications must be accompanied by:

- An Agreement to Cooperate signed by the applicant and the LBHA in any jurisdiction in which the applicant proposes to provide services.
- For accreditation-based licenses, the applicant will need to provide proof of Accreditation from one of the Maryland Department of Health approved Accreditation Organizations. For a copy of the Agreement to Cooperate, please go to https://bha.health.maryland.gov/Pages/newforms.aspx.

Operating a program under COMAR `10.63 requires your ongoing compliance with the regulation. Please read and familiarize yourself with the most current regulation - **COMAR 10.63 Community-Based Behavioral Health Programs and Services**. To review the regulations on-line, or order a copy, please go to: https://dsd.maryland.gov/Pages/COMARHome.aspx

This is a fillable document, which means that you may complete it electronically. You must then print it out, sign where indicated, and then submit it with all required supplemental materials to bha.licensing@maryland.gov. **Completed applications are reviewed in the order that they are received, and in-person applications are not accepted.**

Please fill in the requested information completely, entering "N/A" in sections that don't apply.

- ***If this application is incomplete or missing any of the documentation required, it will be returned. (COMAR 10.63.06.02B).***
- ***Submission of intentionally false or misleading information will result in denial of the application and may lead to inability to seek licensure and further disciplinary action.***

Submit the application in 2 pdf documents, as follows:
PDF A: Organizational information (Required for all Applications) pages 2-7 & PDF A checklist.
PDF B: Program site/service information 10-13 (except for residential rehabilitation program sites with three or fewer beds) **& Attestations are required for each program type: 14-24**

Please return completed application electronically to: **bha.licensing@maryland.gov only.**

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.

Part A: Organization Information - Submit on PDF A

Complete all spaces or add N/A if it does not apply:

1. **APPLICANT ORGANIZATION INFORMATION:** The corporate/business name of the provider/program, hereafter referred to as the "Provider", must match what is registered with the Maryland Department of Assessments and Taxation (SDAT).

2. **Application type: ☐New application ☐Renewal ☐Relocation**
   ☐Change in Ownership ☐Adding service

3. **Trade/Program Name**
4. **SDAT #**

5. **DBA Name, if applicable (Must be registered with SDAT)**

6. **Other Names used by the organization (if applicable):**

7. **Organization Corporate Address and/or mailing address (for Official notifications, etc.)**

Street				
City				
State		Zip Code	Telephone	
Email (for formal correspondence)				

8. **Organization Published Address (for directories and public information purposes) ☐ Same as above.**

Street				
City				
State		Zip Code	PublicTelephone	
Email (for public access)				
Organization Public Website				

Organizational Contacts

9. Organization owner/CEO - Individual with signatory authority on behalf of the organization:

..

☐Mr ☐Ms ☐Mrs ☐Dr		Preferred Pronouns:
First Name:		Last Name:
Credential		Email:
Organizational Title:		Phone:

10. Name/Credential of Primary Licensing contact:

☐Mr ☐Ms ☐Mrs ☐Dr		Preferred Pronouns:
First Name:		Last Name:
Credential		Email:
Organizational Title:		Phone:

11. Name/Credential of individual authorized to act on behalf of the organization in the absence of the Owner/CEO/Executive Director:

☐Mr ☐Ms ☐Mrs ☐Dr		Preferred Pronouns:
First Name:		Last Name:
Credential		Email:
Organizational Title:		Phone:

12. Other contact names/credentials:

Name	Email	Phone

13. Ownership Information: Enter the name and social security number or tax identification of any individual or entity with a 5% or more interest in the Program/s being licensed. (Attached an additional page if necessary). If your organization is a nonprofit, submit a copy of IRS 501-C non-profit status.

Name	SSN or Tax Id	% Ownership Interest in Program
If your program is a 501 c (3) non-profit please check here and submit a copy of IRS 501 non-profit status.		☐

14. Parent Organization: Enter the name of any parent organization of which the applying organization is an affiliate or subsidiary. If there are multiple levels of ownership, please enter the names of additional levels. (You may be asked to provide additional information concerning ownership and management at all levels).

Parent:	
Next level up:	
Next level up:	

15. 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 accreditation organization survey report of the program, and a copy of the **final letter or certificate** of accreditation for the program.

☐ Accreditation Commission for Health Care (ACHC)
☐ Council on Accreditation (COA)
☐ Council on Accreditation of Rehabilitation Facilities (CARF)
☐ The Joint Commission (TJC)
☐ The National Commission on Correctional Health Care (NCCHC)

16. Attach the following items.

☐Most recent behavioral health accreditation **survey report**
☐Any **plans of correction** or **quality improvement plans** required by the accreditation organization survey report of the program.
☐Final letter or certificate of accreditation for the program.

17. ATTESTATION THAT PROGRAM COMPLIES WITH SPECIFIC PROGRAM & SERVICE DESCRIPTION(S).
(Note: The term provider in attestations refers to the Applicant Organization listed in Item 1.)

I hereby affirm that the Provider 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 Part A and Part B of this application.

`

(Signature of owner or controlling partner/CEO) _____ (Date) _____

Printed Name of attestor:

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

I affirm that **the Provider** is in compliance, and shall remain in compliance, 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)__ _____

Printed Name of attestor:

---

19. ATTESTATION OF COMPLIANCE WITH COMAR 10.01.18, SEXUAL ABUSE AWARENESS AND PREVENTION TRAINING (required for staff and participants in publicly funded psychiatric rehabilitation programs for adults and minors, residential rehabilitation programs, and supported employment programs.)

I affirm that the Provider shall comply with COMAR 10.01.18, Sexual Abuse Awareness and Prevention Training.

(Signature)_____ (Date)_____

Printed Name of attestor:

---

20. Attestation concerning housing programs associated with outpatient treatment facilities

I affirm that any housing referral, housing, housing subsidy, or other supports provided by the Provider or its affiliates does not require attendance or participation in the services provided by the Provider. I further attest that any housing provided to program participants either directly or through agreement with other organizations is either a licensed residential program, a certified recovery residence, or a licensed landlord if required by the jurisdiction. (Please provide further details in an attachment).

(Signature)_____ (Date)_____

Printed Name of attestor:

---

21. REQUIRED DISCLOSURES (check all that apply and provide all documentation supporting or demonstrating the information disclosed): (check one for each of the following)

☐**YES** ☐ **NO** Has there been a revocation of a license, certificate, or approval issued within the previous 1 from any in-State or out-of-State provider previously or currently associated with the applicant?

☐**YES** ☐ **NO** 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.

☐**YES** ☐**NO** 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 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**_ _____

☐**YES** ☐**NO** Is there any conflict of interest between the provider and any individual potentially receiving services?

☐**YES** ☐**NO** Does the organization and/or any individual employed by, or volunteering with the organization, appear on the Medicaid exclusion list, OIG Exclusion list and/or the SAMS exclusion list.

☐**YES** ☐**NO** Does this organization provide or coordinate housing directly, through affiliates or through agreements with other organizations?

---

22. Affidavit:

I affirm that the above statements (in question # 19) are true. I affirm that I have legal authority to sign for the provider and bound the provider to any legal obligations.

(Signature)_____ (Date)_____

Printed name of attestor:

CHECKLIST OF REQUIRED ATTACHMENTS FOR ORGANIZATION – Attachment A

23. 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 COPIES OF THE FOLLOWING:

- ☐ 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); form is available https://health.maryland.gov/bha/Pages/newforms.aspx (Forms - Providers)
- ☐ 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 Part A of this Application.
- ☐ Copy of documented proof of the program's good standing status with SDAT **Not required for State or Local Government Agencies** https://egov.maryland.gov/BusinessExpress/EntitySearch (date must be printed on page)
- ☐ **Copy** of organizational chart showing staffing by program/service **(include name, credentials, job title)**
- ☐ **Copy** of patient safety plan

●●●

24. 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 accreditation organization. survey report of the program;
- ☐ Organization's response to corrective action plans outlining how issues will be corrected;
- ☐ Copy of the final letter or certificate of accreditation for the program.

●●

25. NON-ACCREDITATION BASED LICENSE APPLICANTS:

- ☐ Copy of the program's client grievance policy *(COMAR 10.63.05.07C)*
- ☐ Copy of the program's DUI Curriculum or receipt for purchased commercial curriculum. *(COMAR 10.63.05.05)*

●●

INFORMATION REQUIRED FOR SPECIFIC PROGRAM TYPES

26. RESIDENTIAL PROGRAM SPECIFIC INFORMATION (Required for all organizations offering Residential Services).

- ☐ Completed Attestation concerning housing (See Question #18)
- ☐ Safety Plan
- ☐ Community Relations plan
- ☐ Lease agreement or deed for each residential property owned or operated by the program
- ☐ List of all affiliated organizations who receive housing referrals
- ☐ Copy of housing policy
- ☐ Any rental licenses, recovery residence certification, or other certification or license related to the property.
- ☐ Patient lease agreement

27. RESIDENTIAL REHABILITATION PROGRAMS (RRP) and/or GROUP HOMES:

- ☐ Copy of the **CSA or LBHA** (whichever is appropriate) annual site inspection report/certificate of approval (COA) (*COMAR 10.63.04.05 J)*
  Total number of Beds across all sites with 3 or less beds: **Insert #**_ ______ (do not include group home beds with 4 or more beds)
- ☐ Copy of the program's policy regarding the managed intervention plan *(COMAR 10.63.04.05 K)*

●●

28. Attestation:

I am the practitioner, administrator, or authorized professional representative of this group, and hereby affirm that all information given by me in Part A and Part B of this application is true and complete to the best of my knowledge and belief.

I understand and agree to provide new attestations if any of the key staff listed in Part B of this application changes.

Signature ____ Date_________________

Printed Name of attestor:

Part B Site Specific Information (SEPARATE APPLICATION FOR EACH SITE)

Licensed Program Site Information (Complete a separate Part B application for EACH physical site. For Residential Rehabilitation (RRP) program sites with three or fewer beds, you may link multiple sites to a single office address)

29. Site Information

Name of Site (Optional)	
Street Address of Program Site	
County/City of Program Site	

30. At this program site:

A. Does the Organization: ☐ OWN or ☐ RENT/LEASE. **If Rent/Lease, attach a copy of lease which must extend a least a year beyond application date or be auto-renewed**.

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, please explain in detail:

C. Does the Organization have exclusively held space in which confidential information may be locked and accessed? ☐ Yes ☐ No

D. Does the Program share employees/staff/services with any other Program/entity, including shared receptionist? ☐ Yes ☐ No

If yes, which employees are shared, and with whom:

E. Does the site hold any other licenses issued by other agencies within the Department of Health? ☐ Yes ☐ No

If yes, please list licenses held:

31. In the table below, please check all program and/or service types applied for at this location.

For Residential Services, "capacity" means the total number of beds. For Outpatient Services, capacity means the total number of distinct individuals projected to receive services in each month **within six months of licensure based on the staffing shown in this application.** If necessary attach a description of staffing plans to allow for service growth.

Services	Capacity (# of unique individuals served in each month)	Site Identifiers

	# Beds	# Adults	# Minors	NPI #	Medicaid # (If assigned)
☐ **Behavioral Health Crisis Stabilization Center (BHCSC)** (COMAR 0.63.03.21)					
☐ 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) - **must also have OMHC and Level 1***					
☐ **Intensive Outpatient Treatment Level 2.1 Program** *(COMAR 10.63.03.03)*					
☐ **Mobile Crisis Team** (MCT) *(COMAR 10.63.03.20)*					
☐ **Mobile Treatment Services Program** (MTS) *(COMAR 10.63.03.04)*					
☐ **Opioid Treatment Services** (OTP) *(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 - Level 3.1 Low Intensity Program** *(COMAR 10.63.03.11)*					
☐**Residential - Level 3.3 Medium Intensity Program** *(COMAR 10.63.03.12)*					
☐**Residential -Level 3.5 High Intensity Program** *(COMAR 10.63.03.13)*					

☐**Residential -Level 3.7 Intensive Inpatient Program** *(COMAR 10.63.03.14) (Requires Certificate of Need from MHCC)*					
☐**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)* ***State or local government entity only***					
☐**Supported Employment Program** (SEP) *(COMAR 10.63.03.16) with PRP*					
☐**Withdrawal Management Service** *(COMAR 10.63.03.18)*					

32. Each program site must submit operation hours for each program (Add additional sheets if necessary)

		Daily						
Program Type	**Weekly Total hours**	**Mon.**	**Tues.**	**Wed.**	**Thurs.**	**Fri.**	**Sat.**	**Sun.**
A.								
B.								
C.								
D.								
E.								

33. Please check which specialty populations are provided at this site: ☐Pregnant Women with Children

☐ 8-507

☐ Mental Health IOP services offered under OMHC.

☐ Mobile Treatment Services providing Assertive Community Treatment Fidelity Model of Care (ACT)

Other: Please list:

34. Is the facility ready for a virtual or 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 1 month from date of application submission.*

●●

The following services require additional attestations. See the following pages. Please complete those applicable to your application and include in PDF B. Other attestations may be removed or ignored.

Behavioral Health Crisis Stabilization Center (BHCSC)	DUI Education Program (DUI)
Intensive Outpatient Level 2.1 (IOP-SUD)	Mobile Crisis Team (MCT)
Mobile Treatment Services (MTS)	Outpatient Mental Health (OMHC) (one required for multiple sites)
Opioid Treatment Program (OTS/OTP)	Psychiatric Day Treatment Program (PDTP)
PRP-Adults (PRP-A)-requires one per site.	PRP-Minors (PRP-M)-requires one per site.
Withdrawal Management Services (WMS)	

ATTESTATIONS:

35. Behavioral Health Crisis Stabilization Center (BHCSC) (COMAR 10.63.03.21)

A BHCSC must:

1. Behavioral Health Crisis Stabilization Center (BHCSC)

Must be open and accessible to walk-ins 24 hours a day, 7 days a week.
multidisciplinary team consisting of the following staff: ***(attach copies of current licenses)***:

A. Primary Psychiatrist or Psychiatric Nurse Practitioner (Medical Director) ***(attach copy of name(s) current license for Medical Director and all psychiatrists/psychiatric nurse practitioners)***.
B. Physician on call 24 hours/day (attach name and copy of current license)
C. Registered nurse ***(attach copy of current license for all nurses)***.
D. Program Director who is a licensed mental health professional operating at the independent level of practice responsible for the overall management and operation of the BHCSC **(*attach name and copy of current license).***
E. Additional Licensed Mental Health Professionals **(*attach copy of current license for all additional licensed mental health professionals)***.

Affidavit:

Under the penalties of perjury, acknowledge that I, _____[**Insert Name]** 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 least 20 hours per week.

I was hired for the medical director role, working ___ hours on _____(Date).

By completing this form, I attest that I have committed to assume full responsibility for the medical director role. I have not been offered nor received payment or other inducement to sign this application. I understand that providing any false or misleading information is a violation of the Maryland False Health Claims Act, which carries a penalty of up to $10,000 and I may also be reported to the appropriate licensing boards for disciplinary action.

I have listed below all the programs and organizations where I currently work, including contractual positions. Other employers, position, and hours:

Employer: _____Position: _____Hrs./wk_____

Employer: _____Position: _____Hrs./wk_____

Employer: _____Position: _____Hrs./wk_____

`

(Signature)_____(Date)_____

`

Print Name: _____

36. **DUI Education Program** *(COMAR 10.63.05.05)*

Required to have an instructor who, at a minimum, are certified as a Certified Supervised Counselor—Alcohol and Drug, as defined by Health Occupations Article, Title 17, Annotated Code of Maryland

☐ DUI Education instructor license minimum credential Certified Supervised Counselor-Alcohol and Drug (attach copy of license/certification)

☐Supervisor Information if applicable (supervision contract and board approval)

Affidavit:

Under the penalties of perjury, acknowledge that I am the DUI Instructor of the Provider applicant. I specifically acknowledge that I possess the minimum qualifications outlined in COMAR 10.63.05.05 and that my license/certification is in good standing with the respective Health Occupational Board.

By completing this form, I attest that I have committed to assume full responsibility for the instructor role and am not providing a signature to obtain licensure. I understand that **any false information will be reported to the appropriate licensing boards as Fraud/Misrepresentation.**

(Signature)_____ (Date)__ _____

Printed name of attestor: **Email:**

37. Mobile Crisis Team (MCT) (COMAR 10.63.03.20)

A Mobile Crisis team shall employ the following staff:

A. At least one licensed Mental Health Professional available at all times - either face-to-face or via telehealth - who is licensed at the independent practice level, eligible to oversee the staff of the team, and eligible to complete an emergency petition. ***(attach copy of name and current license for licensed mental health professional(s) that meet this criteria that are employed by the MCT program)***
B. Additional licensed Mental Health Professionals that do not meet all criteria above ***(attach copy of name and current license for all other licensed mental health professionals employed by the MCT program)***
C. Second in-person team members (if not a Licensed Mental Health Professional). **(attach copy of name and current license/certification if applicable)**

Affidavit:

Under the penalties of perjury, acknowledge that I, _____ [Insert Name] am the licensed mental health professional described in A. above who is assigned to the Mobile Crisis team of _____ [**Insert Corporate/Business Name]**. I specifically acknowledge that I am a licensed mental health professional in good standing with my respective Health Occupations Board, meet the criteria in A. above, have overall responsibility for clinical services, and am on-site or providing clinical assessment via HIPAA compliant telehealth at least 20 hours per week.

By completing this form, I attest that I have committed to assume full responsibility for this role. I have not been offered nor received payment or other inducement to sign this application. I understand that providing any false or misleading information is a violation of the Maryland False Health Claims Act, which carries a penalty of up to $10,000 and I may also be reported to the appropriate licensing boards for disciplinary action.

I have listed below all the programs and organizations where I currently work, including contractual positions. Other employers, position, and hours:

Employer: _____Position: _____Hrs/wk_____

Employer: ____________________Position: ________________Hrs/wk_______

Employer: ____________________Position: ________________Hrs/wk_______

(Signature)_____________________ (Date)______________________

`

Print Name: ____

●●

38. **Mobile Treatment Services Attestation** (MTS) *(COMAR 10.63.03.04)*

Minimum Required Staff (attach copy of each current licenses):

A. Psychiatrist/ CRNP-PMH,
B. Registered Nurse
C. Licensed Certified Social Worker-Clinical (LCSW-C)

Affidavit: (must be completed by the individual who fills the role of Psychiatrist or CRNP-PMH.)
Under the penalties of perjury, acknowledge that I am the psychiatrist or CRNP-PMH of Provider's Mobile Treatment Services program. 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 least 20 hours per week.

By completing this form, I attest that I have committed to assume full responsibility for the psychiatrist or CRNP-PMH role and am not providing a signature to obtain licensure.

I have listed below all the other programs and organizations where I currently work. (Attach additional sheets if working at more than 3 additional organizations)

Employer (including contractual)	Position	Hours/week

`

(Signature)_____ (Date)_____

Printed Name of Attestor: Email:

39. **Opioid Treatment Services Attestation** *(COMAR 10.63.03.19)*

A separate form is required for each licensed program site.

All OTPs are to provide services **6 days per week** per SAMHSA regulation.

List all mobile and Remote locations (and attach approvals from DEA/OCSA)

☐ **OTP Mobile**

Sites: _____

_____

☐ **OTP Remote**

Sites: _____

_____

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

A. 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 current license, resume, and Board Certification)***; **or**
B. Is certified in added qualifications in addiction psychiatry by the American Board of Psychiatry and Neurology, Inc. ***(attach copy of Board Certification).***

Affidavit:

Under the penalties of perjury, **I** acknowledge that I am the medical director of Provider's Opioid Treatment Service program. 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. I further confirm that my license is not under any State or federal government restriction.

I have listed below all the other programs and organizations where I currently work. (Attach additional sheets if working at more than 3 additional organizations)

Employer (including contractual)	Position	Hours/week

`

(Signature)_____ (Date)_____

Printed Name of Attestor: Email:

40. ATTESTATION FOR OUTPATIENT MENTAL HEALTH CENTER (OMHC) *(COMAR 10.63.03.05)*

One attestation required across multiple sites, if run as a single coherent entity.

A. An OMHC shall employ a medical director, who may be responsible for **multiple program sites within the same organization. Only one attestation is required for the medical director for the organization:**

1. Is a psychiatrist ***(attach copy of current license)***; or
2. Psychiatric nurse practitioner ***(attach copy of current license)***.

B. Multidisciplinary team consisting of at least 3 disciplines. ***(attach copies of current licenses)***:

Affidavit:

Under the penalties of perjury, acknowledge that I am the medical director of Provider's Outpatient Mental Health Center. 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 least 20 hours per week.

I was hired as the medical director role, working ___ hours on ____________________(Date)

By completing this form, I attest that I have committed to assume full responsibility for the medical director role and am not providing a signature to obtain licensure. I understand that **any false information will be reported to the appropriate licensing boards as Fraud/Misrepresentation.**

I have listed below all the other programs and organizations where I currently work. (Attach additional sheets if working at more than 3 additional organizations)

Employer (including contractual)	Position	Hours/week

`

(Signature)_______________________________ (Date)_________________

Printed Name of Attestor: Email:

●●

41. Psychiatric Day Treatment Program (PDTP) *(COMAR 10.63.03.08)*

A. Licensed Psychiatrist (attach copy of current license)
B. Licensed RN (attach copy of current license)
C. Licensed Mental Health Professional (attach copy of current license)

Affidavit:

Under the penalties of perjury, acknowledge that I am the medical director of provider's Psychiatric Day Treatment Program. I specifically acknowledge that I am a psychiatrist, have overall responsibility for clinical services, and am on-site or providing clinical oversight via HIPAA compliant telehealth at least 20 hours per week.

I was hired as the psychiatrist role, working ___ hours on _____(Date)

By completing this form, I attest that I have committed to assume full responsibility for the medical director and am not merely providing a signature to obtain licensure. I understand that a**ny false information will be reported to the appropriate licensing boards as Fraud/Misrepresentation.**

`

(Signature)_____ (Date)_____

Printed Name of Attestor: Email:

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

An attestation is required for each licensed site.

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

A. Licensed mental health professional; **or** certified by the Commission on Rehabilitation; Counselor Certification; or certified by the Psychiatric Rehabilitation Association ***(attach copy of current license/certificate, resume)***; and
B. 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.

Rehabilitation Specialist Name: _____ Credentials: _____
Rehabilitation Specialist Contact Phone: _____

Affidavit:

Under the penalties of perjury, I acknowledge that I the Rehabilitation Specialist for Provider's Psychiatric Rehabilitation Program-Adults at [Enter street addressed of licensed site], 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 number of hours required per week according to the provisions outlined in COMAR 10.63.03.09D.

I was hired into the role of Rehabilitation Specialist working _ hours per week on (date) _____

By completing this form, I attest that I have committed to assume full responsibility for the Rehabilitation Specialist role, responsible for directing the program, and am not merely providing a signature to obtain licensure.

I have listed below all the other programs and organizations where I currently work. (Attach additional sheets if working at more than 3 additional organizations).

Employer (including contractual)	Position	Hours/week

(Signature)_____ (Date)_____

Printed Name of Attestor: Email:

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

An attestation is required for each licensed site.
A PRP-M shall be under the direction of a rehabilitation specialist who:

A. Has a minimum of 2 years direct care experience working with youth with a serious emotional disorder.
B. 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 current license/certificate)***; and copy of resume; and
C. Is employed at least 20 hours per week when the program serves less than 30 individuals or at least 4 hours per week when the program serves 30 individuals or more. Hours worked must coincide with the normal operating hours of the Program.

Rehabilitation Specialist Name: _____ Credentials: _____
Rehabilitation Specialist Contact Phone: _____

Affidavit:

Under the penalties of perjury, I acknowledge that I am the Rehabilitation Specialist for Provider's Psychiatric Rehabilitation program-Minors at [Enter Street address of licensed site], 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-M for number of required hours according to the provisions outlined in COMAR 10.63.03.10C. I was hired into the role of Rehabilitation Specialist working _____ hours per week on (date) ____

By completing this form, I attest that I have committed to assume full responsibility for the Rehabilitation Specialist role, responsible for directing the program, and am not merely providing a signature to obtain licensure.

I have listed below all the other programs and organizations where I currently work. (Attach additional sheets if working at more than 3 additional organizations)

Employer (including contractual)	Position	Hours/week

`

(Signature)_____ (Date)_____

Printed Name of Attestor: Email:

***44.* Withdrawal Management Service** *(COMAR 10.63.03.18)*

Associated Level of Care:

☐ Level 1 Outpatient
☐ Level 2.1 Intensive Outpatient
☐ Level 2.5 Partial Hospitalization
☐ Level 3.1 Residential Low Intensity
☐ Level 3.3 Residential Medium Intensity
☐ Level 3.5 Residential High Intensity
☐ Level 3.7 Residential Intensive
☐ Opioid Treatment Services

Medical Director/Physician/Nurse Practitioner/Physician Assistant Name, **Copy of Professional License, DEA License Reg # with effective date.**

____

Will the withdrawal management service require:

A. The dispensing of methadone, Yes ☐ No ☐
If yes: Is the program licensed as an OTP? How will methadone be acquired? _

____

B. Buprenorphine/suboxone: Yes ☐ No ☐
If yes: practitioner must have Schedule 3 authority (must be identified on DEA license)

Affidavit:

Under the penalties of perjury, **I** acknowledge that I __________________ [Insert Name] am the treating physician of _________________[**Insert Program Name**]Withdrawal Management Services. I specifically acknowledge that I hold all the appropriate credentials to provide withdrawal management services. I further confirm that my license is not under any State or federal government restriction.

(Signature)____ (Date)________________

Printed Name of Attestor: Email:

●●

CHECKLIST OF REQUIRED ATTACHMENTS FOR EACH PROGRAM SITE AND FOR SPECIFIC PROGRAM TYPES

45. **CHECKLIST 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 APPLICATIONS APPLYING FOR A SPECIFIC PROGRAM LICENSE AT A SITE FOR THE FIRST TIME

☐ Business plan that outlines:

- o **Details about Staffing in relation to caseload over the first six months of service**

FOR ALL APPLICANTS COPIES OF THE FOLLOWING:

☐Fire Inspection Report/Permit- Not required for State or Local Government owned Buildings

☐ Use and Occupancy Permit- Not required for State or Local Government owned Buildings

☐Copy of organizational chart showing staffing by program/service **(include name, credentials, job title)**

☐Copy of lease/rental agreement if leasing program location – Lease must be for at least one year from application date.

☐ Credentials for licensed staff and staff specified in COMAR 10.63.

FOR BEHAVIORAL HEALTH CRISIS STABILIZATION CENTERS BHCSC)

☐ Staffing plan

☐ Training plan

☐ Schematic of building

FOR MOBILE CRISIS TEAMS

Staffing plan

☐ Training plan

☐ Dispatch Protocol

FOR DUI EDUCATION

☐ On initial licensure, a full copy of the curriculum to be used.

FOR SUD RESIDENTIAL LEVEL 3.7

☐ **Certificate of Need (CON)**

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

●●

`