GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

2024 APPLICATION
FOR CERTIFICATION AS A
DEPARTMENT OF BEHAVIORAL HEALTH CERTIFIED PROVIDER

Return completed application to Certification Division electronically to dbh.certification@dc.gov. When submitting your typed application, please keep all pages in sequence.

PROGRAM	NAME:	
	ADDRESS:	
	CITY, STATE, ZIP:	
	TELEPHONE:	
	FAX NUMBER:	
	AGENCY E-MAIL:	
PARENT ORGANIZATION	NAME:	
	ADDRESS:	
	CITY, STATE, ZIP:	
	TELEPHONE:	WARD:

NAMES OF EXECUTIVE STAFF – MHRS AND SUD APPLICANTS ONLY

CHIEF EXECUTIVE OFFICER:	EMAIL:
PROGRAM DIRECTOR:	EMAIL:
CLINICAL DIRECTOR:	EMAIL:
MEDICAL DIRECTOR:	EMAIL:
CHIEF FINANCIAL OFFICER:	EMAIL:
QUALITY IMPROVEMENT OFFICER	EMAIL:

NAMES OF EXECUTIVE STAFF – FSMHC APPLICANTS ONLY

CHIEF EXECUTIVE OFFICER:	EMAIL:
PSYCHIATRIST	EMAIL:
ADMINISTRATOR	EMAIL:
CORPORATE COMPLIANCE OFFICER	EMAIL:

2. DISCLOSURES

When answering the following questions the word "you" refers to the CEO, Program Director-or any other title given the administrator(s) with fiduciary and programmatic responsibility for the organization.

1. Are you a Maryland Service Provider wanting to provide Community Support for the residents of the District of Columbia?
   □ Yes □ No *If yes, please answer questions 2-5.*

   1b. Are you a Maryland Service Provider applying for Certification as a DBH Core Service Agency?
   □ Yes □ No *If yes, according to the DBH Provider Certification for Out-of-State Applicants (see* Policy *340.3), you are **ineligible** to apply for Certification as a DBH Core Service Agency Provider.*
2. Have you or your organization ever lost or had suspended a professional certification, accreditation, licensure, or contract for failure to maintain required standards, misconduct, or any other reason?
   □ Yes □ No *If yes, please explain on a separate sheet.*
3. Do you or any member of the executive staff have any past (within 7 years) or pending conviction(s)?
   □ Yes □ No *If yes, please explain on a separate sheet.*
4. Do you or the organization have any past (within 7 years) or pending litigation(s)?
   □ Yes □ No *If yes, please explain on a separate sheet.*
5. Have you or your organization ever been involved in any federal, state or local investigation?
   □ Yes □ No *If yes, please explain on a separate sheet.*
6. Do you or the organization owe any debt to the IRS, the District of Columbia, or any other state or local government?
   □ Yes □ No *If yes, please explain on a separate sheet.*
7. Are you or your organization licensed or certified to conduct business in any other state?
   □ Yes □ No *If yes, please provide details and provide a copy of your license or certification.*
8. Is your agency non-profit? □ Yes □ No If yes, you must have a board of directors.
   Is your agency for-profit? □ Yes □ No

3. NATIONAL ACCREDITATION

Please select which National Accrediting body your agency is accredited with □ the Commission Accreditation of Rehabilitation Facilities (CARF) □ the Council on accreditation (COA) □ The Joint Commission (TJC)

Please provide a **current** copy of your National Accreditation certificate along with your most recent accreditation report with your application.

4. REQUEST FOR EXEMPTION FROM CERTIFICATION STANDARDS

Providers seeking certification may request exemption from certification standards that may interfere with service provision. Prepare one (1) form for each exemption requested. [Duplicate this form as needed.]

Will you be seeking an exemption from any certification standard(s)? No □ Yes □

If "yes", please specify the certification standard from which exemption is sought, provide your reasoning for seeking the exemption, and explain why it is appropriate.
STANDARD/CITATION:

JUSTFICATION FOR EXEMPTION:

5. OWNER(S), OFFICERS OR AGENTS

Please note: You may reference an attachment if it includes all the information requested below.

1) Last Name _____First Name_____

Title _____ Telephone # _____

Address _____
Street City State Zip

2) Last Name _____ First Name_____

Title _____ Telephone # _____

Address _____
Street City State Zip

3) Last Name _____First Name_____

Title _____ Telephone # _____

Address _____
Street City State Zip

4) Last Name _____First Name_____

Title _____ Telephone # _____

Address _____
Street City State Zip

5) Last Name _____First Name_____

Title _____ Telephone # _____

Address _____
Street City State Zip

6. MEDICAID INFORMATION

National Provider Identifier (NPI) Number:

Current or Pending Medicaid Provider?	□ Yes □ No	Medicaid #:
Previous Medicaid Provider?	□ Yes □ No	Medicaid #:
Suspended or Revoked?	□ Yes □ No	Date Suspended or Revoked:

If yes, specify and explain:

Reinstated?	□ Yes □ No	Date of Reinstatement:
Current Medicaid Provider in another state?	□ Yes □ No	State, Medicaid #:
Previous Medicaid Provider in another state?	□ Yes □ No	State, Medicaid #:
Suspended or Revoked?	□ Yes □ No	Date Suspended or Revoked:

If yes, specify and explain:

Reinstated?	□ Yes □ No	Date of Reinstatement:
Are there any other Medicaid programs for which you or your organization is certified for (e.g., Free Standing Mental Health Clinic)?	□ Yes □ No	Medicaid #:

If yes, please describe and provide Medicaid number:

7. TYPE OF CERTIFICATION SOUGHT

Check below all services that apply. State the service type or level of care provided and the number of patients that can be served when operating at capacity.

PROGRAM TYPE (Check all that apply)

□ Substance Use Disorder Treatment Services

□ Recovery Support Services

□ Mental Health Rehabilitation Services

□ Free Standing Mental Health Clinic

Demographics (Check all that apply)

□ Youth □ Adults □ Both

For currently certified DBH Providers ONLY

Are you applying to add a new service(s)? □ Yes □No

SERVICES (*Select all that apply*)

Substance Use Disorder Treatment Level of Care & Specialty Services ***(select all that apply)***	**Capacity**
□ Level 1 Outpatient	
□ Level 2.1 Intensive Outpatient Program	
□ Level 2.5 Day Treatment	
□ Level 3.1 Clinically Managed Low-Intensity Residential	
□ Level 3.3 Clinically Managed Population-Specific High-Intensity Residential	
□ Level 3.5 Clinically Managed High-Intensity Residential (Adult) or Clinically Managed Medium-Intensity Residential (Youth)	
□ Level 3.7 WM Medically Monitored Intensive Inpatient Withdrawal Management	
□ **Specialty Services (Note: Some specialty services are required at certain levels of care)**	
□ Adolescent – Community Reinforcement Approach (ACRA)	
□ Medication Assisted Treatment (MAT)	
□ Medication Management	
□ Parents with Children	
□ Supported Employment (SUD)	

Recovery Support Services ***(select all that apply)*** ***For providers who only want to provide Recovery Support and are NOT certified for any other Level of Care***	**Capacity**
□ Level RSS	
□ Environmental Stability (Optional)	

Mental Health Rehabilitation Services ***(select all that apply)***	**Capacity**

Provider Type	
□ Core Services Agency	
□ Child Choice	
□ Health Home ***(Please See Addendum)***	
□ Subprovider	
□ Specialty Provider	
Services	
□ Diagnostic/Assessment	
□ Medication-Somatic Treatment	
□ Counseling and Psychotherapy	
□ Community Support	
□ Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	
□ Child-Parent Psychotherapy for Family Violence (CPP-FV)	
□ Supported Employment (MHRS)	
□ Stabilization Program ***(Please See Addendums)***	
□ Comprehensive Psychiatric Emergency Program (CPEP)	
□ Comprehensive Psychiatric Crisis Stabilization	
□ Adult Mobile Crisis and Outreach	
□ Youth Mobile Crisis	
□ Rehabilitation/Day	
□ Intensive Day Treatment	
□ Trauma Recovery Empowerment Model (TREM)	
□ Trauma System Therapy (TST)	
□ Community-Based Intervention □ Level I (Multi-Systemic Therapy-(MST) □ Level II □ Level III □ Level IV (Functional Family Therapy-(FFT)	
□ Assertive Community Treatment (ACT)	
□ Transitional Planning	
□ Clubhouse	

8. EVIDENCE BASED PRACTICES

DBH Certification to provide evidence based practices, or services like Health Homes, may require a provider to obtain training and certification from the Department or outside accrediting bodies, such as the national organization that oversees particular evidence based practice. Applications for those certifications (e.g. as a CBI provider providing Functional Family Therapy) must include that information.

Do you provide Evidence Based Practice? □ Yes □ No

If yes, please describe and include certificates, licenses or training records to demonstrate proficiency.

9. PROGRAM DESCRIPTION

Please provide a detailed description of each program for which you are seeking certification. The description should include detailed information about your prospective consumer/client populations, your staffing plan (including the functional role of each position) for each program, and your clinical expertise and philosophy of treatment. Your program description must comply with the requirements detailed in the regulations governing the certification you are seeking. (*Please attach separate sheets as necessary.)*

Hours of Operation: _____ Days_____
Projected Capacity: _____

Age range of children accepted to your Parents with Children SUD program:_____

Describe program and population targeted for service (treatment model, program curriculum):

Describe staffing plan, including how staffing will be handled if you have multiple sites:

Describe services planned at each site, and how your program will meet DBH requirements for service delivery:

10. ACCESSIBILITY

Providers must have the means to provide translation services and accessibility under the American

with Disabilities Act.

Check box if your organization offers: *(check all that are applicable)*

□ Language Line Services for limited or non-English speaking consumers

□ Live Interpreters for limited or non-English speaking consumers

□ On-site American Sign Language interpretation, or Video remote interpreting (VRI),

□ Document translation as necessary for limited or non-English speaking consumers.

□ TDD/TTY (Telecommunications Device for the Deaf or hard of hearing)

□ Relay Access for the Deaf or Hard of Hearing

□ Report quarterly on Non-English Proficient/Low English Proficient encounters

□ Wheelchair and restroom accessible facilities or in at least one facility if operating more than one location with similar services.

□ Handicapped parking (if parking is provided)

11. ADDITIONAL ORGANIZATION INFORMATION

The following are not services directly reimbursed by the Department. Check box if your organization offers: (check all that are applicable)

□ Childcare services (Parents with Children programs are required to make this available)
□ Private Transportation
□ Food and clothing support

12. SERVICES OFFERED THROUGH REFERRAL OR AFFILIATION AGREEMENTS

Required for sub-providers ONLY Describe the program/agency with which you have an agreement and indicate the type of services offered to your clients. *Attach a copy of the Affiliation Agreement between your agency and the DBH certified agency.*

DUPLICATE THIS PAGE AS NECESSARY.

Days/Hours of Operation: _____ Capacity: _____
Identify agency and address:

_____

_____

Population targeted for service and service(s) provided:

_____

_____

13. SPECIFIC QUALIFICATIONS, TRAINING, AND EXPERIENCE OF STAFF

For: **All** staff including the Executive Staff. The information in the top half of the form must be supplied for all staff. The information in the bottom half of the form **(b.) must** be supplied for all licensed staff. Providers may also supply a complete staff list with resumes containing all of the identified information

in **(a.)** rather than using this form. Applicants applying for any part of the Stabilization Program, please skip section 13 but please be sure to complete addendum(s).

Duplicate this page as necessary. **a. One (1) page for each staff person.**

Last Name	First Name	Middle Name
Title		
Fulltime Employee □ Part-time □ *(No. of Hours/week):*	Supervisory □	Non-Supervisory □
Duties:		
Communicable disease testing/vaccinations (as required) □yes □ no		
Employed or a volunteer at another DBH Certified Provider □yes □ no		
Name of Program:		

b. The following section is to be completed for staff requiring licensure/ certification

Degree(s)	Date Received	Name and Location of Institution

Certificates, Licenses, Registrations (attach copies)	Number	Expiration
Background and Professional Experience		

14. LICENSES, CERTIFICATIONS, AND OTHER REQUIRED DOCUMENTS

Check each that applies and ATTACH A COPY

Type	License/Registration or Certificate Number	Expiration Date
REQUIRED DOCUMENTS		
A complete current staff list which includes hire date and PT or FT status		
Current licenses under other District of Columbia law or regulation, i.e., Basic Business License: (Please specify)		
Certificate of Good Standing/Clean Hands Form issued by Office of Tax and Revenue – Certificate of Clean Hands is NOT valid if it is more than **30 days** old.		
Proof of insurance coverage as indicated in 3413.32, 6311.11, or 3004.9		
Client's Rights Statement		
Notice of Privacy Practices		
Confidentiality Forms and Releases		
Certificate of Need (For Residential Treatment Programs)		
Equal Employment Opportunity Compliance Documents (Mayor's Order 85-85, dated June 10, 1985)		
Certificate of Occupancy (Not needed for Re-Certification unless new sites have been added)		
DCRA Inspection for new Residential facilities, as outlined in 6325.6		
DCRA permits and post-inspection report for any work done in the past 12 months that required DCRA approval.		
Certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services		
For all unlicensed staff members, attach a copy of the criminal background check results contained in D.C. Official Code§44-551 *et seq*., Unlicensed Personnel Criminal Background Check - https://www.fbi.gov/services/cjis/identity-history-summary-checks/list-of-fbi-approved-channelers-for-departmental-order-submissions. Background check must not be older than 45 days of the person's hire date		
For all programs serving children, attach a copy of the criminal background check requirements contained in the Criminal Background Checks for the Protection of Children Act of 2004 and the Emergency Amendment of 2006 *Must be completed annually for District of Columbia and or State of Residency ***Not optional for FSMHC applicants***		
FSMHC applicants only: Identification of the psychiatrist(s) who will provide clinical and administrative direction, and provide direct services as outlined in 3005.2		
FSMHC applicants only: A signed contract or attestation letter for all clinical staff as outlined in 3002.18 (c) 2		
For Medication Assisted Treatment applicants: SAMHSA Certification and accreditation by a national accreditation body that has been approved by SAMHSA.		

For Medication Assisted Treatment applicants: Current DEA registration		
For Medication Assisted Treatment applicants: Current registration under DCMR Title 22B Chapter 10		
CPEP applicants only: A signed attestation letter as outlined in 8025.15 and 8015.5		
CPEP applicants only: A signed and submitted contract with a licensed and bonded security company		

National Accreditation		
Current certification from the Commission Accreditation of Rehabilitation Facilities (CARF)		
Current certification from the Council on Accreditation (COA)		
Current certification from the Joint Commission (TJC)		
Other National Accreditation Body		

All of the following must be included with your application. Please mark with a √ to indicate your submission.

Ownership and Governance

- □ List of Board members and titles
- □ DC 1513 Form-Ownership Statement
- □ Organization chart that reflects lines of authority with governing body
- □ Copies of referral or affiliation agreements, or written agreements with any DBH certified provider providing program services (MHRS and SUD applicants only)

Financial Information

- □ Annual audit by a certified public accounting firm. *Applies only to agencies 1) with revenue at or above three hundred thousand dollars ($300,000.00); and 2) agencies that have been in operation for more than one year.*
- □ Anticipated or actual program budget, along with Board-approved financial reports explaining variations in budgeted activity.
- □ Documented evidence adequate funding to provide the services for which you seek Certification – which includes a Line of Credit sufficient to support ninety (90) days of operating expenses and or last 4 months (120 days) of consecutive financial bank statements from a verified banking institution
- □ Proof of insurance for residential programs as described in 6311.11.

Human Resources

- □ Health Professional Licensing Administration (HPLA) License Verification https://app.hpla.doh.dc.gov/Weblookupcs/ & a copy of current paper license for all licensed staff.
- □ History of professional license revocation or admitting privilege revocation for all staff (Not needed for Re-certification Applications unless has changed since Initial Certification).
- □ Office of the Inspector General (OIG) Medicaid Exclusion checks for all staff and Board Members. (https://exclusions.oig.hhs.gov/)
- □ CPR certification as per 6319.2 for at least two staff members (one staff member for RSS applicants) who will be present during all hours of operation.
- □ Licensed dietician or nutritionist license for residential treatment programs.

15. REQUIRED POLICIES & PROGRAM DOCUMENTS

Check marks indicate policies required for the following certifications:

For Deemed Status Applicants Only: Asterisk (*) marks indicate the following policies do NOT need to be sent for applicants claiming "Deemed Status":

	SUD/RSS	MHRS	FSMHC	CPEP
Abuse or Neglect (consumers) Policy (6308.2; 3413.37, 3413.39; 8018.g)	X	X		X
Access to records (8022.6c;d)				X
Admission, Exclusion, Transfer, and Discharge Policy (6313.2d, 6313.3 a,b; 6313.2d; 3413.11; 3006.4a; 8012.3a;b) *	X	X	X	X
Advance Instruction Policy (3409.7, 3409.8)		X		
Affiliation Agreement (8012.1j)				X
Affiliated Provider Policy / Collaboration Policy (6313.1l; 3415.7; 8012.1j)	X	X		
Anti-Discrimination Policy (6320.1k; 3413.27, 3006.4c) *	X	X	X	
Assertive Community Treatment Organizational Plan (3426.8)		X		
Assertive Community Treatment Service Policy (3426.4)		X		
Billing and Payment Policy (3413.34; 3006.4d) *		X	X	
Care Coordination Policy (3006.4e)			X	
Child Care & Monitoring Policy (6326) (PWC programs only)	X			
Clinical Records Maintenance and Storage Policy (3006.4f)			X	
Community Based Intervention Organizational Plan (3425)		X		
Community Support Organizational Policy (3421)		X		
Community Support Service Policy (3421)		X		
Complaint and Grievance Policy (6320.4; 3409.4; 3006.4g; 8019.4) *	X	X	X	X;
Consent to Treatment Policy (6329.6; 3409.5; 3006.4h) *	X	X	X	
Consumer and Family Education Policy (CSAs Only) (3414.5) *		X		
Consumer Privacy Release of Information Policy (3006.4s)			X	
Client Conduct Policy (6313.3j) *	X			
Client/Consumer Rights & Choice Policies (6320, 6321; 3410; 3006.4n; 8012.3j; 8020.1) *	X	X	X	X
Collaboration Policy (Subproviders and Specialty Providers Only)		X		

(3415.6)				
Continuity of Care Policy (6307; 3405) *	X	X		
Continuity of Operations Plan (6314.1; 3413.10; 8013.1 and DBH Policy 651.2)	X	X		X
Contractor Policy (8012.1i)				X
Control of Stock Pharmaceuticals (8015.26)				X
Control Substance Policy (8007.15; 80012.3)				X
Corporate Compliance Plan (6310.5e; 3413.39;)	X	X		
Counseling Service Policy (6342; 3413.13)	X	X		
Crisis/Emergency Service Policy (6341; 3422)	X	X		
Crisis Intervention/Medical Emergency Service Policy (8012.3e)				X
CSA Affiliation Policy (Subproviders Only) (3415)		X		
CSA Referral Policy (Specialty Only) (3415)		X		
Cultural Competency Policy (3413.10; 3006.4i; 8012.2a; b) *		X	X	X
Diagnostic/Assessment Service Policy (6339; 3418)	X	X		
Disaster Evacuation Plan (8013.1)				X
Disaster Recovery Plan (3006.4j)			X	
Drug and Alcohol Policy (6308.14)	X			
Drug Testing and Screening Policy (6343.4)	X			
Environmental/Safety Policy (6315.1 a-g; 6315.6; 6315.10a,g; 6315.14)	X			
Employee Conduct Policy (6309) *	X			
Fiscal Management Policy (6311; 8010.2) *	X			X
Gender Specific (6313.4)	X			
Grievance Policy (6320.4; 3409.4) *	X	X		
Group education Policy (group size and group leader) (6342) *	X			
Hazardous Environmental Conditions Policy (6313.3 d; 6315) *	X			
Individualized Services Policy (6313.2a)	X			
Infection Control & Universal Precautions Policy (6313.3d; 3413.29j; 3006.4k; 8018.3e)	X	X	X	X
Intensive Day Treatment Organizational Plan (6332; 3424)	X	X		
Intensive Day treatment Service Policy (3424)		X		

Interpreter Policy (6320.1w; 3413.23-25; 3006.4l; 8025.11) *	X	X	X	X
Interpreter Language Access Policy (8025.11)				X
IRP/IPC Review Policy (CSAs Only) (3411)	X	X		
Least Restrictive Setting Policy (6313.2c) *	X			
Major Unusual Incident Policy & Investigation Policy (6308.2) *	X			
Medical Waste Policy (6315.11) *	X			
Medication & Controlled Substance Policy (6313.3o; 3413.29l) *	X	X		
Medication Management (8015.2)				X
Medication Storage and Administration Policy (3006.4m)			X	
Medication Policy (8012.3n)				X
Natural Settings Policy (3413.26; 8012.2c)		X		X
Nutritional Standards Policy (6318)	X			
On-Call System Policy (3414; 3006.4o; 8007.14c) *		X	X	
Outreach Policy (6313.3c; 3414.6g)	X	X		
Patient Funds Policy (6311.10) *	X			
Performance Review Policy (6308.10; 3413.6; 3006.4p; 8007.14) *	X	X	X	X
Personnel Policies & Procedures (6308.13a, c; 8007.14) *	X			X
Plan of Care Policy (3006.4v)			X	
Program Mission Statement, philosophy, purpose, and values (6313.1a)	X	X		
Primary Care Provider Communication Policy (3413.14; 3006.4q)		X	X	
Privacy Policy (6315.15; 6320.1h)	X			
Quality Improvement Policy (6310; 3413.28; 3006.4r; 8009.1) *	X	X	X	X
Records Management Policy (6323; 3413.16; 8012.3g) *	X	X		X
Record Retention Policy (6323; 3413.31) *	X	X		
Rehabilitation/Day Organizational Policy (3423)		X		
Rehabilitation/Day Service Policy (3423)		X		
Release of Consumer Information Policy (6322) *	X			
Residential Program House Rules (6323.6-7)	X			
Safe Workplace Policy (6313.3g) *	X			
Special Needs Policy (client & population) (6312.2b)	X			

Staff Development & Training & Orientation Policies (8007.13)				X
Staff Selection or Human Resources Policy (6308.7; 3413.4; 8007.9) *	X	X		X
Staff Relationships (8008.1d)				X
Subcontractor Policy (3414.5) *		X		
Supervision and Peer Review Policy (6308.11; 3413.7; 3006.4t; 8007.12 and DBH Policy 710.38)	X	X	X	X
Supported Employment Organizational Plan (Supported Employment Applications only) (3701.3)		X		
Supported Employment Service Policy (Supported Employment Applications only) (3701.3)		X		
Staff Development, Training & Orientation Policies (6319; 3413.10; 3413.11) *	X	X		
Training Policy (3006.4b; 8018)			X	X
Treatment Philosophy & approach (6313.1g)	X			
Unscheduled Service Access Policy (3413.15) *		X		
Vehicle Use and Safety Policy (6317.1) *	X			
Volunteer Policy (6308.13d, 6313.1m, 6313.3e; 8012.3d) *	X			X

I certify, under penalty of perjury, that the information contained in this application is accurate and complete to the best of my knowledge.

Name: _____ Title: _____

Owner, Officer, or Agent

Signature: _____ Date: _____

Owner, Officer, or Agent

ADDENDUM
FOR HEALTH HOME SERVICES

PLEASE COMPLETE ONE PAGE FOR EACH TEAM

Number of Teams:
Capacity:

LIST STAFFING PATTERN FOR EACH TEAM

TEAM 1

Number of Consumers:	
Health Home Director's Name:	
Full-time Employee	Part-time Employee (how many hours)

Nurse Care Manager's Name:		
License Type	APRN	RN
Expiration Date:		
Nurse Care Manager's Name:		
License Type	APRN	RN
Expiration Date		

NEEDED FOR EVERY 500 CONSUMERS

Primary Care Liaison's Name:		
License Type	APRN	MD
Expiration Date:		

Care Coordinator(s)		
Name:	BS	MS
Name:	BS	MS
Name:	BS	MS
Name:	BS	MS
Name:	BS	MS
Name:	BS	MS

ADDENDUM
FOR
COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP)

Capacity:

NAMES OF EXECUTIVE STAFF	
CPEP PROGRAM DIRECTOR:	EMAIL:
CLINICAL DIRECTOR:	NUMBER:
PSYCHIATRIST:	EMAIL:
QUALITY COORDINATOR:	NUMBER:
DESIGNATED PRIVACY OFFICER:	EMAIL:
MEDICAL RECORDS ADMINISTRATOR:	NUMBER:
SECURITY COMPANY/GUARD(S):	EMAIL: NUMBER:
SECURITY COMPANY/GUARD(S):	EMAIL: NUMBER:
SECURITY COMPANY/GUARD(S):	EMAIL: NUMBER:

Describe security and safety services, staffing plan and evidence of security and safety services that will be present 24hrs/day 7days/week.

□ **Attestation Letter attached**

ADDENDUM
FOR

PSYCHIATRIC CRISIS STABILIZATION

Capacity:

NAMES OF EXECUTIVE STAFF	
PROGRAM DIRECTOR:	EMAIL: NUMBER:
CLINICAL DIRECTOR:	EMAIL: NUMBER:
PSYCHIATRIST:	EMAIL: NUMBER:
QUALITY COORDINATOR:	EMAIL: NUMBER:
DESIGNATED PRIVACY OFFICER:	EMAIL: NUMBER:
MEDICAL RECORDS ADMINISTRATOR:	EMAIL: NUMBER:

ADDENDUM

FOR
YOUTH/ADULT MOBILE CRISIS AND OUTREACH

□ Adult □ Youth □ Both Capacity:

NAMES OF EXECUTIVE STAFF	
PROGRAM DIRECTOR:	EMAIL: NUMBER:
CLINICAL DIRECTOR:	EMAIL: NUMBER:
PSYCHIATRIST:	EMAIL: NUMBER:
QUALITY COORDINATOR:	EMAIL: NUMBER:
DESIGNATED PRIVACY OFFICER:	EMAIL: NUMBER:
MEDICAL RECORDS ADMINISTRATOR:	EMAIL: NUMBER:

ADDENDUM
FOR
TRANSITIONAL PLANNING

Medicaid ID Number:

Location of where services are being held:

Capacity of Program:

Name of qualified Supervisor according to §6510.9:

Names of line staff according to §6510:

Program Description:

ELIGIBLE PROVIDERS MUST BE ENROLLED IN MEDICAID (§6507.1) **AND IN ACCORDANCE WITH THE REQUIREMENTS OF TITLE 29 CHAPTER 94, AS A(N): PLEASE SELECT ONE OF THE FOLLOWING WHICH QUALIFIES YOUR AGENCY ALONG WITH EVIDENCE IN WHICH IT PERTAINS TO:**

□ Mental Health Rehabilitation Services (MHRS) provider; or

□ Adult Substance Abuse Rehabilitative Services (ASARS) provider; or

□ Free Standing Mental Health Clinic (FSMHC); or

□ Federally Qualified Health Center (FQHC)

Other Requirements:

□ A transition planning provider shall participate through a formal agreement with a registered Health Information Exchange (HIE) entity of the DC Health Information Exchange (DC HIE), defined in Title 29 DCMR Chapter 87 (§6507.9).

□ Evidence of how the agency meets each of the requirements according to §6507.2 (a-e)

□ Submit evidence of training according to §6510.8 (e)

Required Policies

The following provider policies shall be submitted for review:

□ Client/Consumer Rights Policy;

□ Language Access Policy; and

□ Client/Consumer Choice Policy.