FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Government of the District of Columbia
Adrian M. Fenty, Mayor

Application for Certification of Substance Abuse Treatment Facilities and Programs

District of Columbia Department of Health
Pierre N.D. Vigilance, M.D., MPH
Director

Addiction Prevention and Recovery Administration
Tori L. Fernandez Whitney
Senior Deputy Director

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

*Base Requirements for Certification**

An applicant shall demonstrate that:	**Check all that Apply**
(a) It is a non-hospital residential, non-hospital detoxification, or outpatient treatment facility or program;	
(b) It offers an organized program for the treatment of drug abuse, alcohol abuse, or any combination thereof;	
(c) It operates under the direct day-to-day supervision of a clinical director, who may or may not be the medical director, with demonstrable training and experience in the treatment of drug abuse and/or alcohol abuse;	
(d) It employs sufficient numbers of professional staff members to deliver adequately the services offered to its patient caseload.	

*Reference Title 29 of the D.C. Municipal Regulations, Chapter 23—"***Certification Standards for Substance Abuse Treatment Facilities and Programs"**.

Complete and sign the following section if you believe your facility is not required to be certified. Return the completed application to the address at the top of page 3. The Department will make a determination regarding your facility and you will be notified in 30 to 90 business days. If it is determined that your program is required to be certified, your application and certification fees will be due prior to scheduling the survey dates. Thank you.

I believe that this facility is not required to be certified because of the following:

_____

_____

_____

_____

_____

(Attach additional sheets if necessary)

_____ _____

Name (please print) **Title**

_____ _____

Signature **Date**

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

*Application for Certification Pursuant to Title 29, Chapter 23 of the District of Columbia Municipal Regulations **

*Please complete **one (1)** application for **each** physical location and **each** type of certification being sought. Return to:* ***Department of Health, 33 N Street, NE, Room 214, Washington, DC 20002 Attention: Lynea Cooper***

Part I, Section I

PARENT ORGANIZATION	**NAME:**	
	ADDRESS:	
	CITY, STATE, ZIP:	
	TELEPHONE:	
PROGRAM	**NAME:**	
	ADDRESS:	
	CITY, STATE, ZIP: WASHINGTON, DC	
	TELEPHONE:	**WARD:**
PROGRAM DIRECTOR	**NAME:**	
CLINICAL DIRECTOR	**NAME:**	
PRIMARY CONTACT	**NAME:**	
	FAX NUMBER:	
	E-MAIL:	

List all other physical sites operated by your organization providing supportive services to clients in the program listed above.

PROGRAM NAME	ADDRESS	SERVICES PROVIDED

*Reference District of Columbia Substance Abuse Treatment and Prevention Act of 1999 (D.C. Law 8-80; D.C. Code § 32-1604).

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part I, Section I *(Continued)*

Type of Certification Being Sought:
(Note: A separate application is required for each type of certification being sought)

*Check below **all services that apply** at this location. State the level of care provided (I, II or III, as specified in Standards), **the number of patients served when operating at capacity**, and briefly describe your service.*

Type of Certification Being Sought		Level of Care	Capacity
Certification for ***Residential Treatment*** for:	☐ Drug Abuse		
	☐ Alcohol Abuse		
Description:			

Type of Certification Being Sought		Level of Care	Capacity
Certification for ***Outpatient Treatment*** for:	☐ Drug Abuse		
	☐ Alcohol Abuse		
☐ Methadone ☐ General ☐ Intensive ☐ Day Treatment			
Description:			

Type of Certification Being Sought		Level of Care	Capacity
Certification for ***Non-Hospital Detoxification*** for:	☐ Drug Abuse		
	☐ Alcohol Abuse		
Description:			

Will you be applying for a Medicaid Provider Number in the next 90 days? ☐ YES ☐ NO

What is your primary targeted population?

☐ **Opiate Abusers seeking narcotic treatment services**

☐ **Youth needing residential treatment**

☐ **Women with Dependent Children needing residential treatment**

☐ **Persons with HIV/AIDS** ☐ **Latinos** ☐ **Sexual Minorities** ☐ **Outpatient** ☐ **Ex Offenders**

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part I, Section II

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

I certify that the information contained on this application is accurate and complete to the best of my knowledge.

Name:_____ Title_____
Owner, Officer, or Agent *(must be listed above)*

Signature _____ Date_____
Owner, Officer or Agent

Notarized: _____ **Date** _____

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part I, Section III

Check each that applies and <u>ATTACH A COPY</u> of the relevant license or certification.

CURRENT CERTIFICATIONS/LICENSES

Type	License/Registration or Certificate Number	Expiration Date
☐ Current certification from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for the treatment of drug abuse, alcohol abuse, or mental illness		
☐ Current certification from the Commission on Accreditation of Rehabilitation Facilities (CARF)		
☐ Current certification from the Council on Accreditation		
☐ Currently certified as eligible for Medicaid reimbursement as a free standing mental health clinic or substance abuse treatment program.		
☐ Currently approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) as meeting its standards for drug and/or alcohol facilities.		
☐ Currently registered with the DEA		
☐ Currently licensed under other District of Columbia governmental law or regulation, i.e., Basic Business License (Please specify)_____		
☐ Currently licensed/certified to provide Child Care (Please specify)_____		
☐ Other (Please specify)_____		
☐ Other (Please specify)_____		

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

REQUEST FOR EXEMPTION FROM CERTIFICATION STANDARDS

PREPARE ONE (1) FORM FOR EACH EXEMPTION REQUESTED. [DUPLICATE THIS FORM AS NEEDED.]

To be considered for an exemption from any certification standard, please complete and submit this form, one for each exemption requested, for review by the Department of Health, with your application.

The following represents the standard that applies to granting exemptions.

If a certification standard interferes with a service provision, the Department may, at its discretion, exempt a certification standard if the exemption does not jeopardize the health and safety of patients, infringe on patient rights, or diminish the quality of the service delivery [Standard 2306.4].

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

If "yes", please specify standard for which exemption is sought and provide compelling justification:

STANDARD:_____

_____

_____

JUSTIFICATION FOR EXEMPTION:_____

_____

_____

_____

_____

Stipulations affecting exemptions :

- **All requests for an exemption from certification standards must be submitted in writing to the Department.**
- **If the Department approves an exemption, such exemption shall end on the expiration date of the facility or program certification, unless the facility or program requests renewal of the exemption prior to expiration of its certificate.**
- **The Department may deny an exemption at any time if the Department makes a determination that a substance abuse treatment facility or program is not in compliance with the provisions of the Act, rules adopted pursuant to this chapter, and applicable District and federal laws or regulations.**

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part II, Section I

Physical Description of Facility

Type of Building

☐ House: Number of Floors _____

☐ Office: Office #_____; Floor(s) Occupied_____

Total # of Floors in the Building _____

☐ Apartment: Apartment #_____; Floor(s) Occupied _____

Total Number of Apartments in the Building _____

☐ Other (Explain)_____

Construction

☐ Brick ☐ Frame ☐ Masonry ☐ Concrete

☐ Steel ☐ Other_____

Part II, Section I
Physical Description of Facility
(continued)

Rooms

List each room in the facility, beginning with the first floor and moving upwards in succession. Indicate if the room is or is not used by the program. If it is used, indicate its use. For residential facilities, include the number of beds per room. **[DUPLICATE THIS FORM IF MORE SPACE IS NEEDED]**

Room	Floor	Use

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part II, Section II

Detailed Description of the Services Directly Provided to Clients

Give a detailed description of each program offered at this physical location. Include a description of your staffing plan for the program, and describe the functional role of the position.

[CHECK ONLY ONE PROGRAM]

☐ Residential Drug Abuse ☐ Residential Alcohol Abuse

☐ Outpatient Drug Abuse ☐ Outpatient Alcohol Abuse

☐ Non-Hospital Detox—Drug Abuse ☐ Non-Hospital Detox—Alcohol Abuse

Hours of Operation: _____ **Capacity:** _____

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

_____

_____

_____

_____

_____

_____

_____

Describe staffing plan:

_____

_____

_____

_____

Part II, Section II
(continued)

Detailed Description of
SERVICES OFFERED THROUGH REFERRAL AGREEMENTS
with other Agencies or Organizations

DUPLICATE THIS PAGE AS NECESSARY. ONE (1) PAGE FOR EACH AGENCY AGREEMENT.

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 agreement).**

Hours of Operation: _____ **Capacity:** _____

Identify agency, and address:

_____

_____

Population targeted for service, and service provided:

_____

_____

_____

_____

_____

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part II, Section III

Specific Qualifications, Training, and Experience of Staff

DUPLICATE THIS PAGE AS NECESSARY. ONE (1) PAGE FOR EACH STAFF PERSON.

Begin with the Program Manager and Clinical Director. All staff persons must complete the top half of the form. The bottom half of the form must be completed by all professional staff only.

Last Name of Staff Person	First Name	Middle Name

Title	FTE	PTE *(No. of Hours)*

Function:	Supervisory ☐	Non-Supervisory ☐
Duties:		
Employed or volunteer at another Substance Abuse Treatment Program		☐yes ☐ no
Name of Program:	☐yes ☐ no	**Tour of Duty:**

The following section is to be completed by *professional staff only* requiring licensure/ certification, etc.

Educational Background		
Degree(s)	**Date Received**	**Name and Location of Institution**

Certificates, Licenses, Registrations (attach copies)	Number	Expiration

Background and Professional Experience

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Part II, Section IV

Additional Information

Please include on this page any additional information that you think should be considered when evaluating your application.

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

Checklist of Items Required for a Complete Application Package

An application for certification shall include the following information:

(Please mark a √ next to each item indicating your submission of these documents.)

Items	√
A completed Application for Certification shall include the following attachments:	
(a) Current organizational chart;	
(b) A business/capitalization plan demonstrating the applicant's financial ability and organizational capability to provide services to the target population. These can be demonstrated by 1) an independent audit, that includes a management letter, and 2) a statement of bank credit worthiness or line of credit; 3) program's budget;	
(c) A description of services and community coordination to be provided to meet the needs of the target population in areas including but not limited to housing, child/day care;	
(d) The number of persons to be served by the facility;	
(e) A description of an advisory or planning committee which includes representatives from the target population, such as, the Advisory Neighborhood Commission, Board of Probation and Parole, Family Services, Head Start; and evidence of their involvement with the development of the program including but not limited to letters of support, minutes of meetings;	
(f) Proof of liability insurance coverage, provided that such coverage includes malpractice insurance of at least one hundred thousand dollars ($100,000), and comprehensive general coverage of at least three hundred thousand dollars ($300,000) per incident. Such coverage shall include coverage of all personnel, consultants or volunteers delivering direct patient care;	
(g) Copies of accreditations issued by a Federal or nationally recognized accrediting body;	
(h) Hours of operation;	
(i) Current Medicaid provided approval;	
(j) Current license or certification under other DC law or regulation, (i.e., childcare, hospital, basic business license, Department of Mental Health); and	
(k) List of all staff providing services to include, but not be limited to, specific qualifications, licenses, certification and training.	
Application forms shall include copies of all certificates of approval, authority, occupancy, or certificate of need required as a precondition to lawful operation in the District, including but not limited to the following:	
(a) District and Drug Enforcement Administration (DEA) controlled substance registrations as required by Chapters 10 of Title 22 of the District of Columbia Municipal Regulation; and 21 CFR, Part 1300 - 1399, respectively;	
(b) Professional health occupations' licenses in accordance with the District of Columbia Health Occupations Revision Act of 1985 Amendment Act of 1994 (D.C. Law 6-99; D.C. Code §2-3301 et seq.);	
(c) Copies of written agreements with any entity providing program services;	
(d) Certification from SAMHSA, CSAT for the operation of a narcotic treatment program or opioid treatment program;	
(e) For corporations, an original Certificate of Good Standing from the Department of Consumer and Regulatory Affairs, Business Regulatory Administration, Corporation Division, and the office of Tax, Finance and Revenue;	
(f) Facility's certificate of occupancy and other certificates documenting compliance with District zoning, fire, and occupancy laws and regulations;	
(g) Clean Hands Act Form;	
(h) Disclosure of Ownership and Control Interest Statement; and	
(i) Current accreditation from national accrediting bodies.	

FOR DOH USE ONLY: *SUBSTANCE ABUSE TREATMENT PROGRAM*
Program Name:_____ Number:_____

"CLEAN HANDS ACT"
CERTIFICATION FORM

TO THE APPLICANT:

PLEASE READ CAREFULLY AND COMPLETELY BEFORE SIGNING.

- A FALSE STATEMENT ON THIS CERTIFICATION REQUIRES THAT THE DEPARTMENT PROCEED IMMEDIATELY TO REVOKE THE LICENSE OR PERMIT FOR WHICH YOU ARE APPLYING, AND FINE YOU $1,000.00.

- THIS CERTIFICATION IS REQUIRED BY THE ***"CLEAN HANDS ACT OF 1996"BEFORE RECEIVING A LICENSE OR PERMIT*** (EFFECTIVE MAY 11, 1996, D.C. LAW 11-118, D.C CODE § 47-2861 et seq.).

I, _____, certify that _____,
(PRINT NAME CLEARLY) **(PROVIDER)**

does not owe more than $100.00 to the District of Columbia Government as a result of:

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Action of 1985, effective March 25, 1986 (D.C Law 6-100; D.C. Code § 6-2901 et seq.);

2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of (1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code § 6-2911 CL et seq.) ;

3. Fines, penalties or interest assessed pursuant to the Department of Consumer and Regulatory Affairs Civil Infraction Act of 1985, effective October 5,1986 (D.C Law 6-42; D.C Code § 6-2701 et. seq.); or

4. Past due taxes.

I understand that if I knowingly falsify this Certification, the Department will move to revoke the license or permit for which I am applying, and to fine me $1,000.00. I further understand that the Department may conduct an investigation to ascertain the veracity of this certification.

I understand that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

_____ _____
SIGNATURE OF APPLICANT **TITLE**

_____
DATE