Maryland
DEPARTMENT OF HEALTH

COMAR 10.63 Online Application Guide

Licensing, Compliance, and Quality Improvement

Division Policy and Planning

Regulatory Authority

- The Behavioral Health Administration issues licenses and certifications in accordance with the following:
- Health General Articles governing Behavioral Health in Maryland
- Code of Maryland Regulations (COMAR)
- Code of Federal Regulations (CFR)
- Licenses issued under COMAR 10.63 include both accreditation and non-accreditation based licenses, as well as approval letters issued to pilot programs, grant programs and programs requesting confirmation of exemption from licensing, as outlined in COMAR 10.63.04. COMAR 10.63 licenses are issued for a specific date range, and must be renewed in accordance with COMAR 10.63.

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New Online Application

- Effective February 1, 2025, BHA will be launching a new online licensure application submission process. This new system was developed in response to a number of pain points identified by providers as well as a review of our current paper-based licensing system.

- To access the new online system please visit the Behavioral Health Administration website BHA Licensing Website

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Important Information

- All fields in this application are **required**. You will not be able to to proceed to the next page until you answer all the questions and attach all required documents

- A separate application is still required for each program site.

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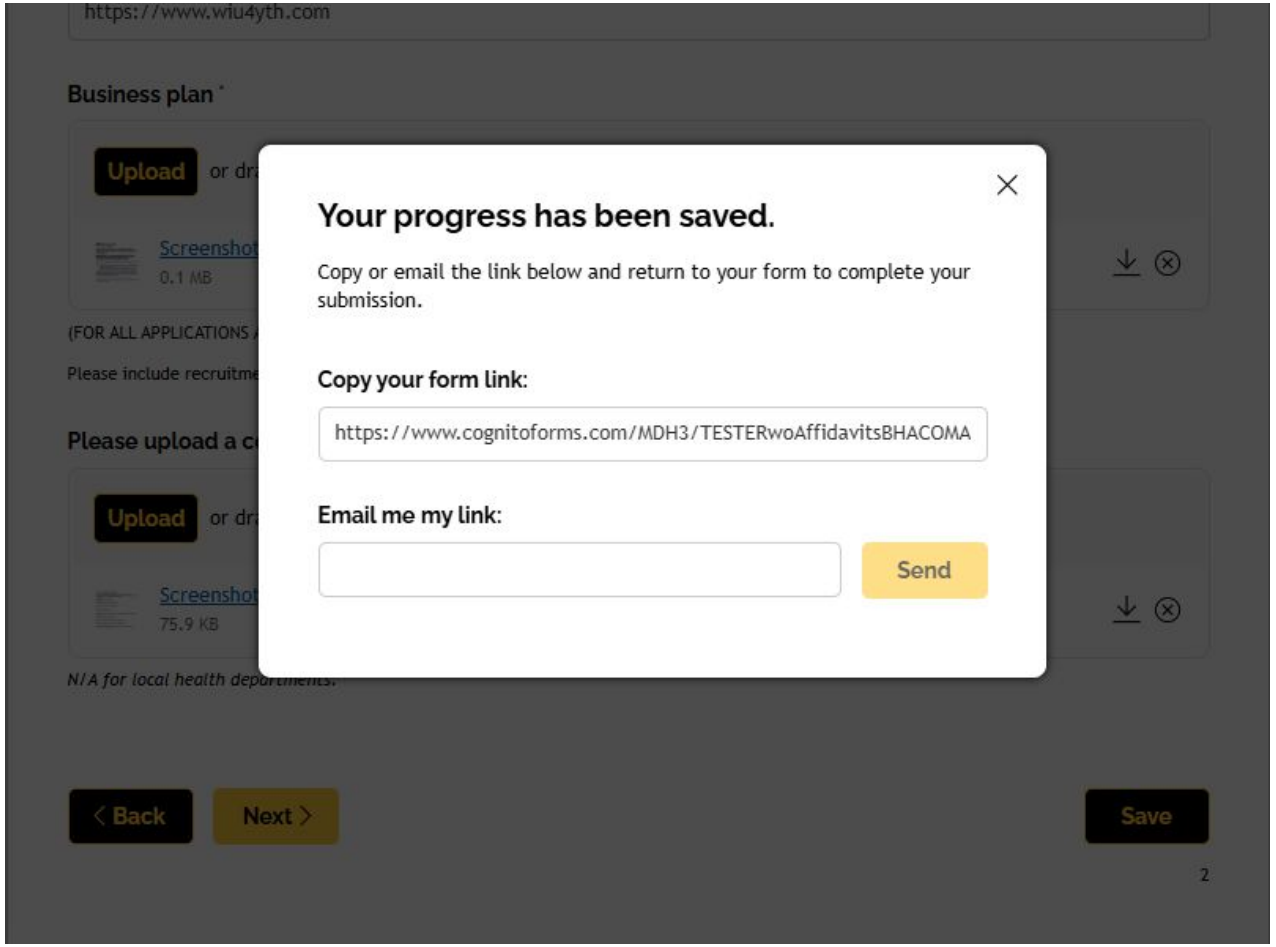
Saving Your Application



- This application has a save function. If you choose to save your application you will be emailed a link to your saved application.
- The application link will remain active for **21 days**. After 21 days the application link will no longer be active and you will be required to start the application over again.

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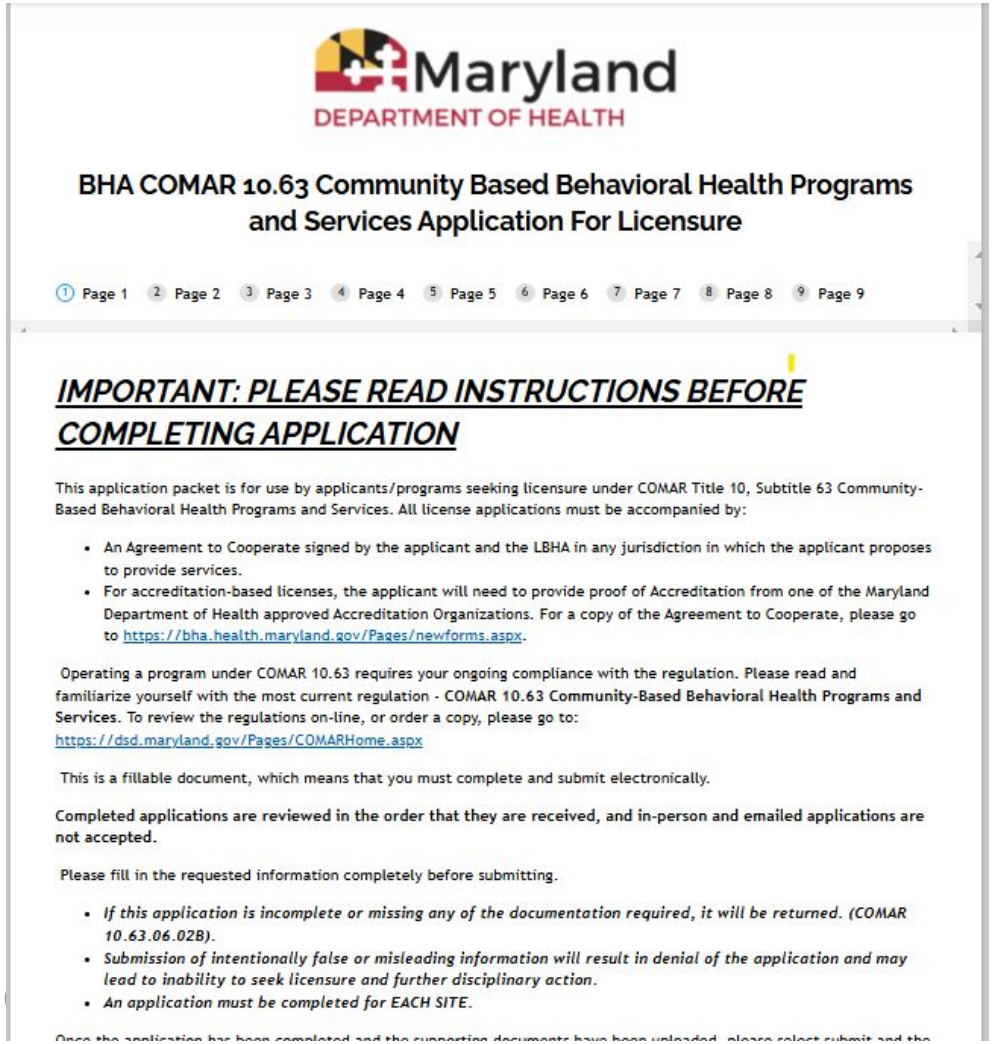
Instructions



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BHA COMAR 10.63 Community Based Behavioral Health Programs and Services Application For Licensure

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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 must complete and submit electronically.

Completed applications are reviewed in the order that they are received, and in-person and emailed applications are not accepted.

Please fill in the requested information completely before submitting.

- ***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.***
- ***An application must be completed for EACH SITE.***

Once the application has been completed and the supporting documents have been uploaded, please select submit and the

- Once you have clicked on the link from the BHA website the instruction page will populate on your screen.
- Please read the entire page carefully.

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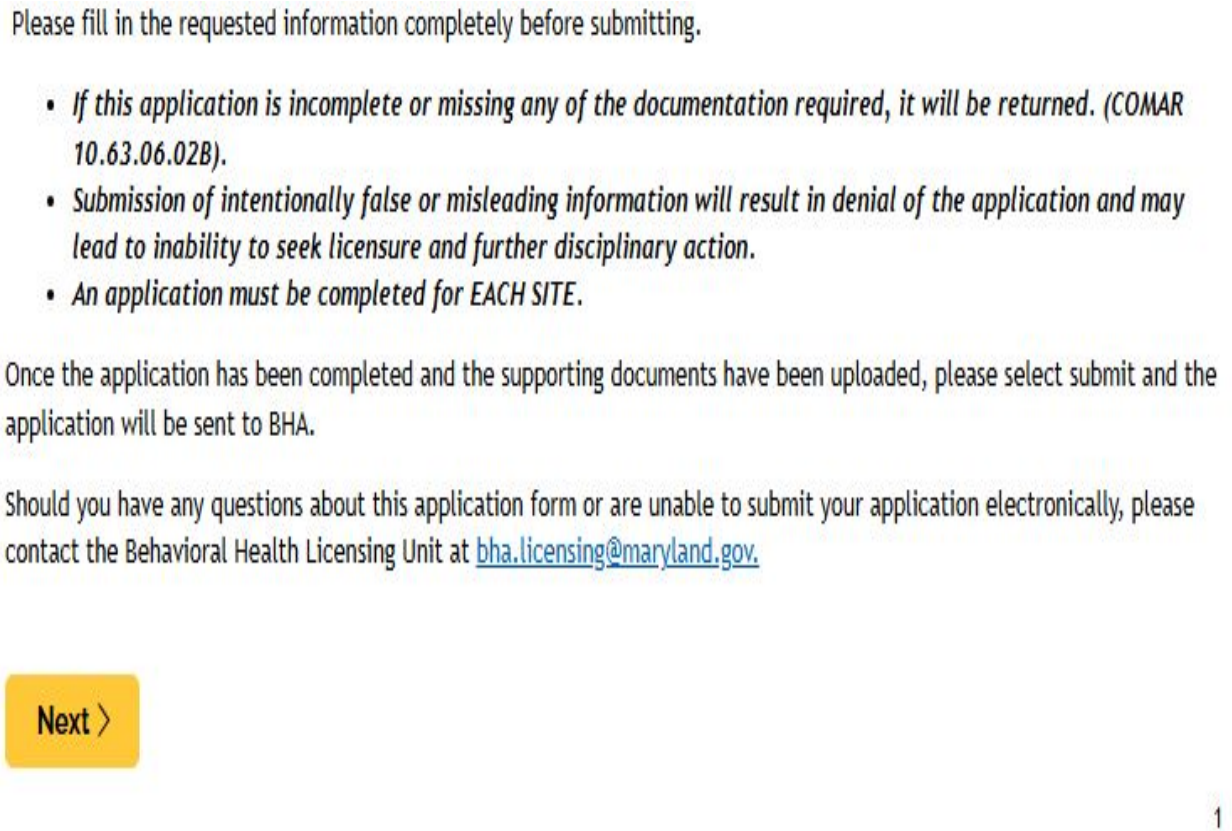
Instructions Page- continued



Please fill in the requested information completely before submitting.

- *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.*
- *An application must be completed for EACH SITE.*

Once the application has been completed and the supporting documents have been uploaded, please select submit and the application will be sent to BHA.

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.

Next 〉

1

- Once you have read the instruction please select 'next' at the bottom left corner when you are ready to proceed.

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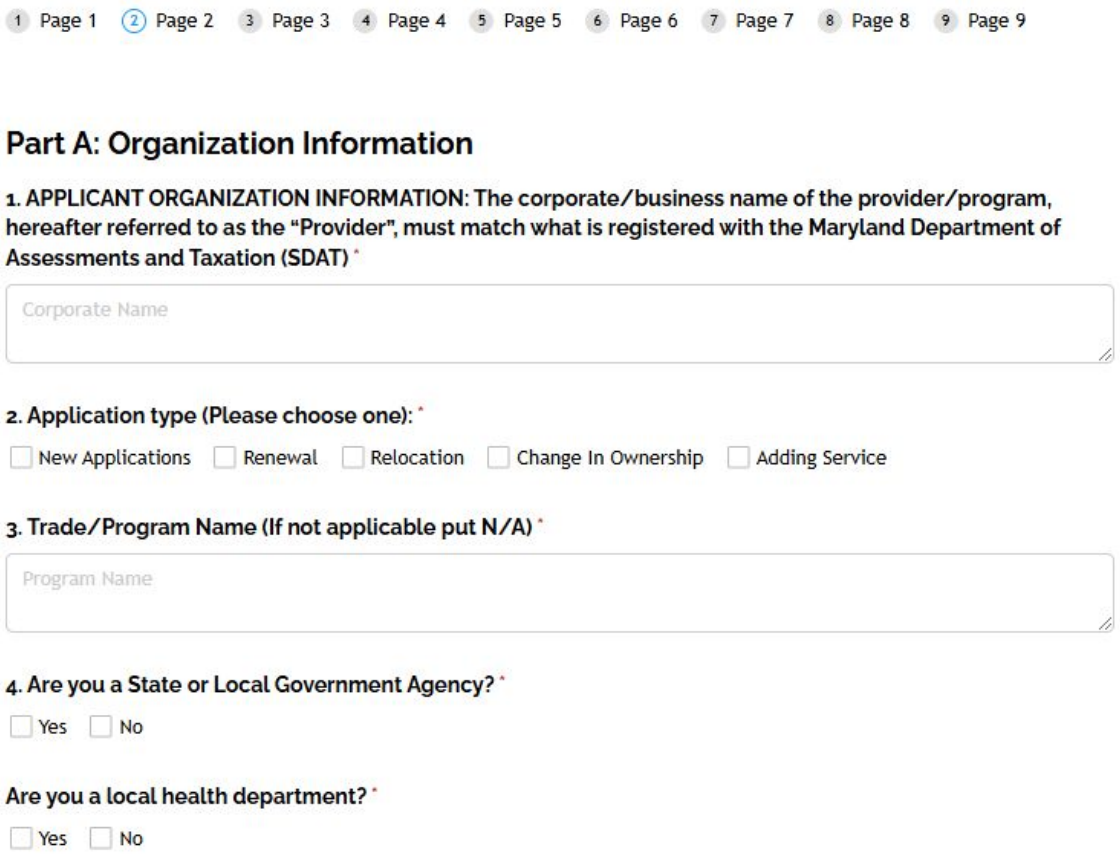
Part A: Organization Information


1 Page 1 2 Page 2 3 Page 3 4 Page 4 5 Page 5 6 Page 6 7 Page 7 8 Page 8 9 Page 9

Part A: Organization Information

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) *

Corporate Name

2. Application type (Please choose one): *

☐ New Applications ☐ Renewal ☐ Relocation ☐ Change In Ownership ☐ Adding Service

3. Trade/Program Name (If not applicable put N/A) *

Program Name

4. Are you a State or Local Government Agency? *

☐ Yes ☐ No

Are you a local health department? *

☐ Yes ☐ No

Questions 1-4:

- Once you select next, "Part A- Organization Information" will populate.
- In the Organization's information section of the application you will start by entering the following information:
- Enter the corporate/business name of the provider/program, **This must match what is registered with the Maryland Department of Assessments and Taxation (SDAT)**
- Select the type of application
- Enter the trade/program name. If not applicable, please type "n/a" in the provided field.
- Identify if you are a local health department

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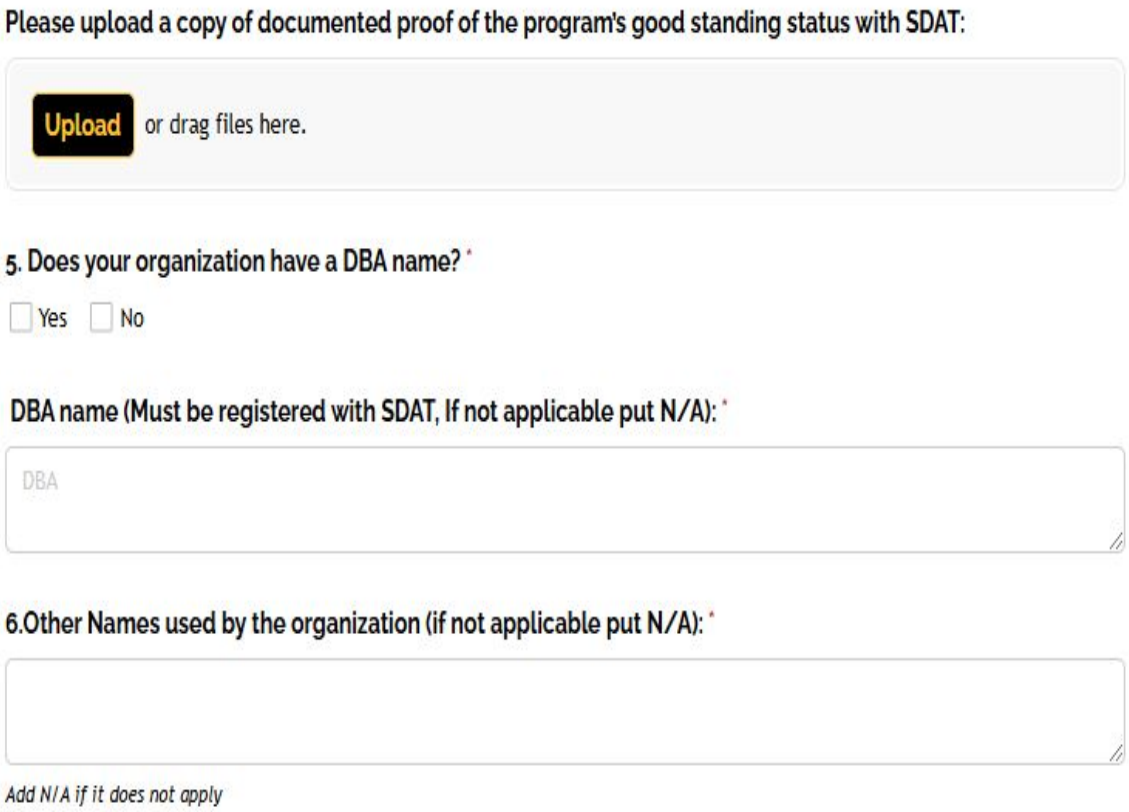
Part A: Organization Information



Questions 5 and 6

- Next you will be required to provide the following information:
  - A copy of your State Department of Taxation and Assessment Good Standing Status
  - Identify if your organization has a DBA name.
    - If there is no DBA name, please select the option no and type “n/a” in the identified field. If yes, please select the option yes and provide the DBA name in the provided field.
  - Identify other names used by the organization.
    - If not applicable, put “N/A” in the provided field.

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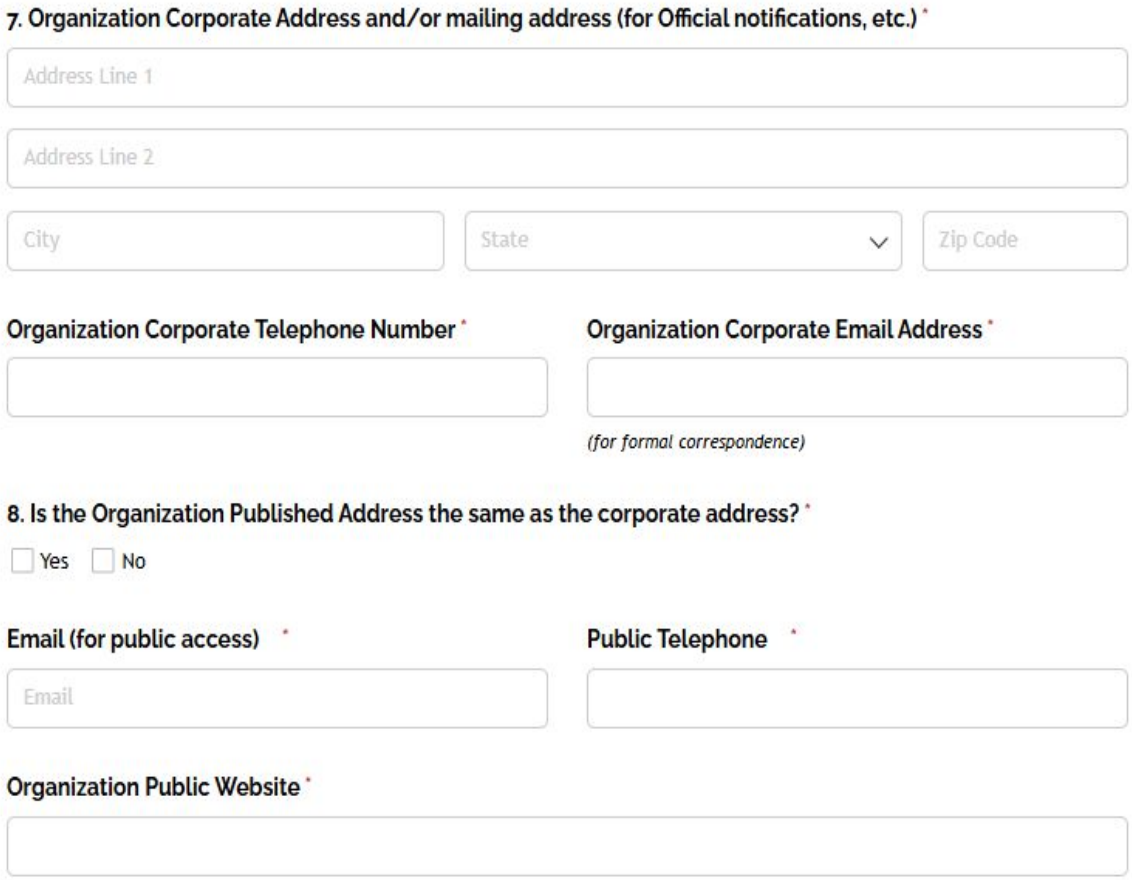
Part A: Organization Information



Questions 7 and 8

- In this section you will enter the Organization's Corporate Information:
  - Address
  - Telephone Number
  - Email Address
- Additionally you will enter the agency's publishable information that will be uploaded to the BHA website.

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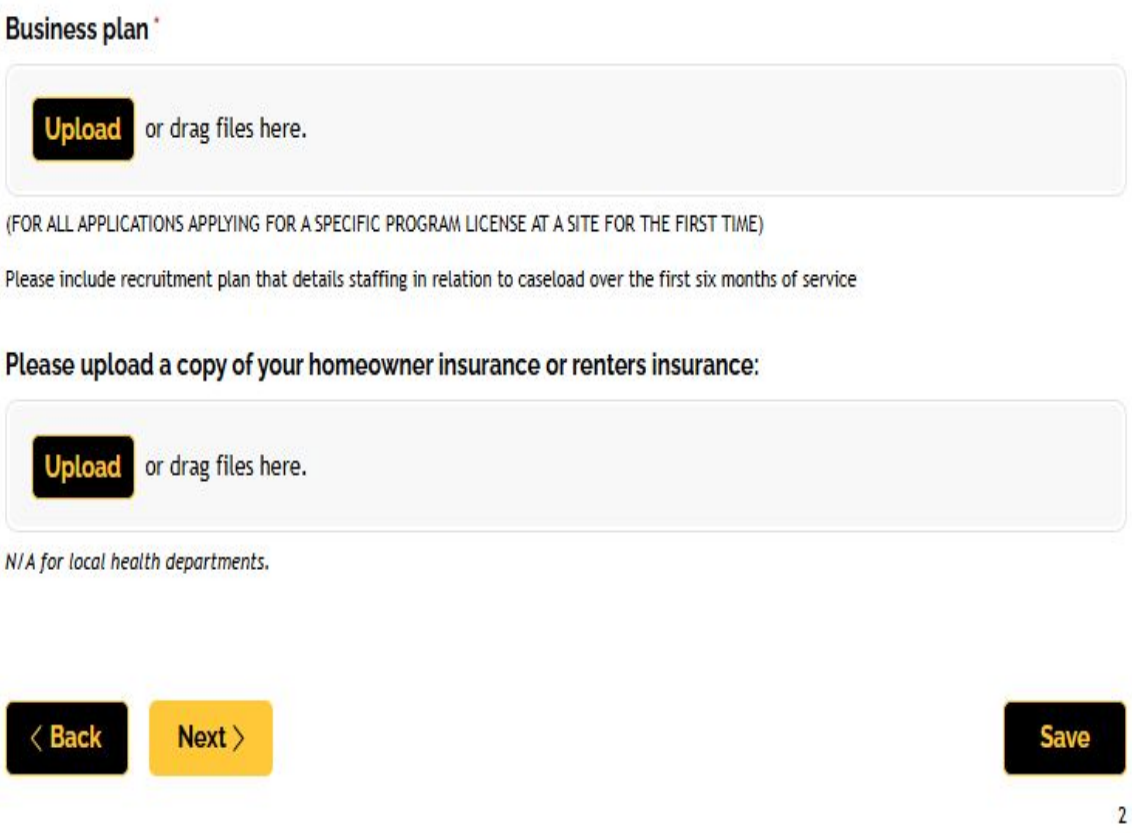
Part A: Organization Information



- If you are applying to be licensed for the first time, you will be asked to provide a business plan. If you are an existing business you will not be required to answer this question.
- All providers will be required to to provide a copy of their insurance policy. This will be uploaded to this section.

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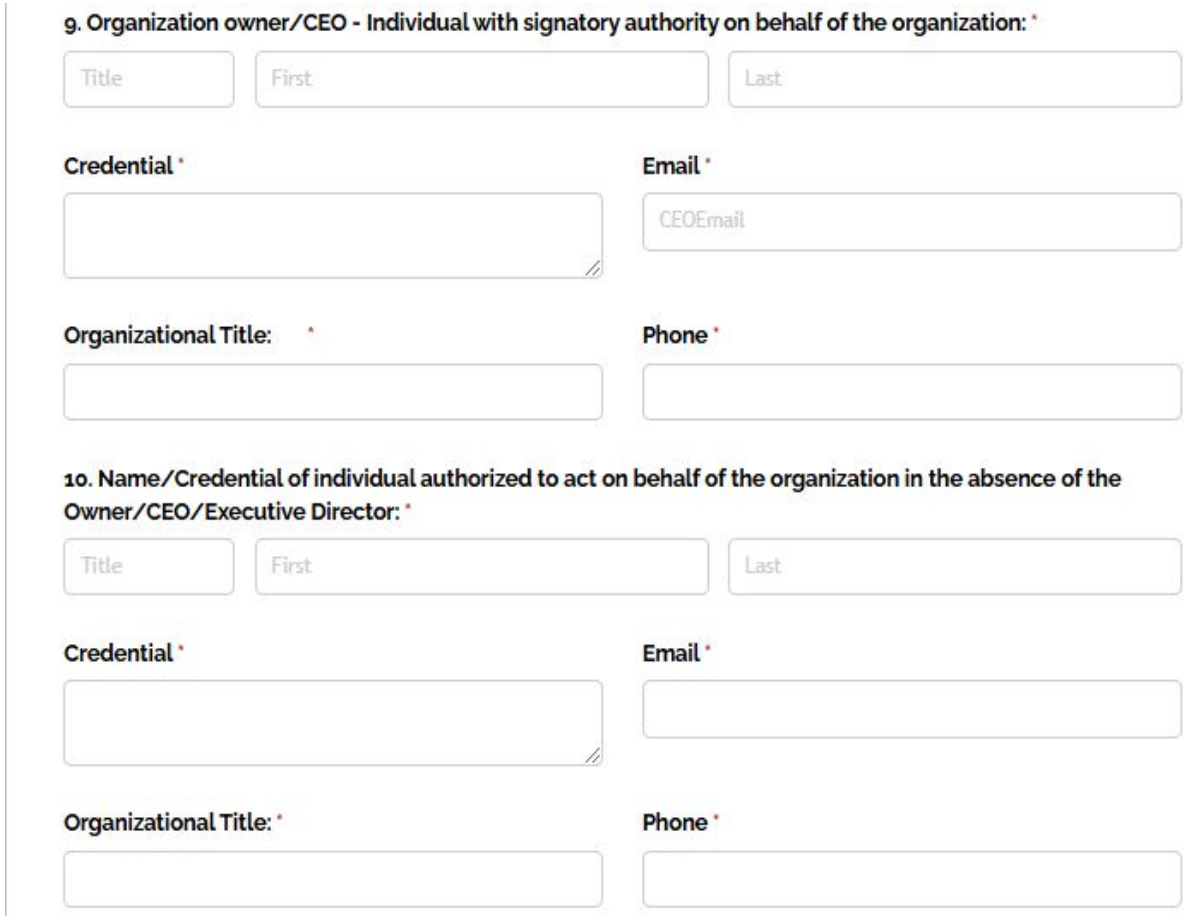
Part A: Organization Information - Organization Contact Information



Question 9

- For the next question, you will enter information for the Organization owner/CEO information. This Individual has the signatory authority on behalf of the organization. Please identify the name,credentials, email, organizational title, and phone number.
- Next, please identify the Name/Credential of individuals authorized to act on behalf of the organization in the absence of the Owner/CEO/Executive Director credentials
- If any field is not applicable, please put “n/a”

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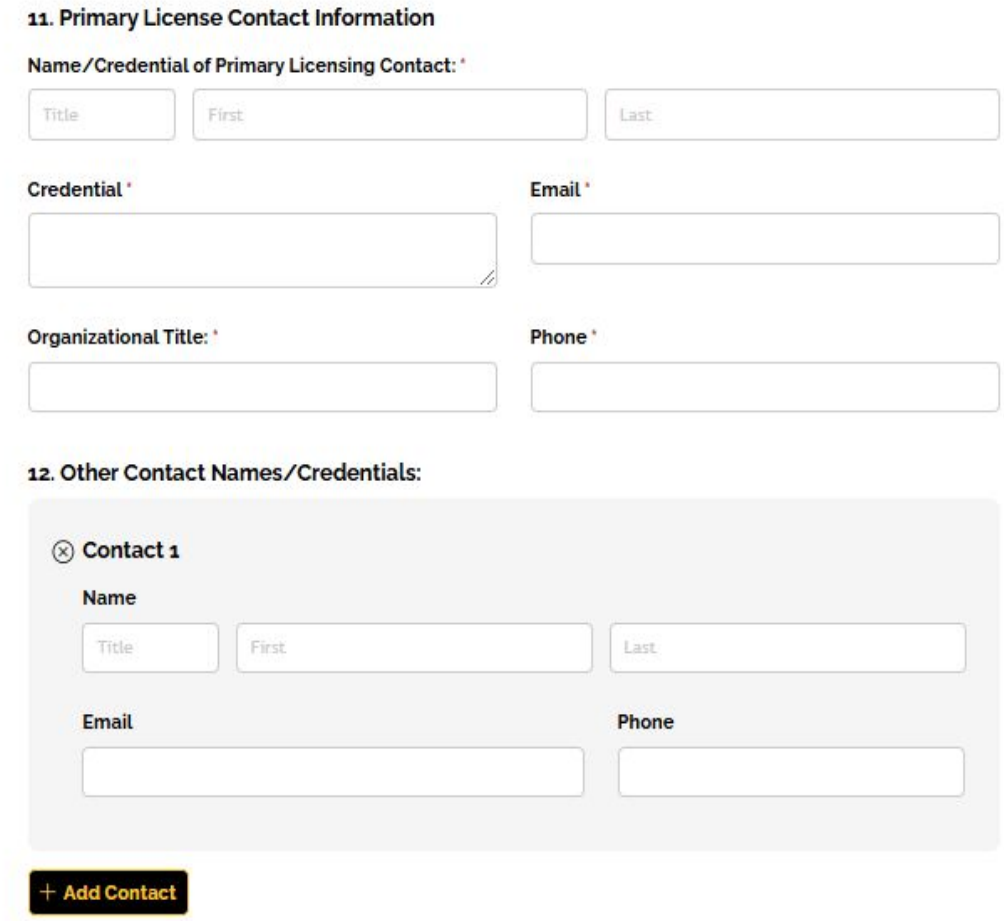
Part A: Organization Information- Primary Licensing Contact



Questions 11 and 12

- This next set of questions is where you will enter the contact information for your primary licensing contact. This is the individual whom BHA will contact if there are questions or concerns regarding your application
- You have the ability to add any number of additional contacts by answering question 12 and using the add contact button

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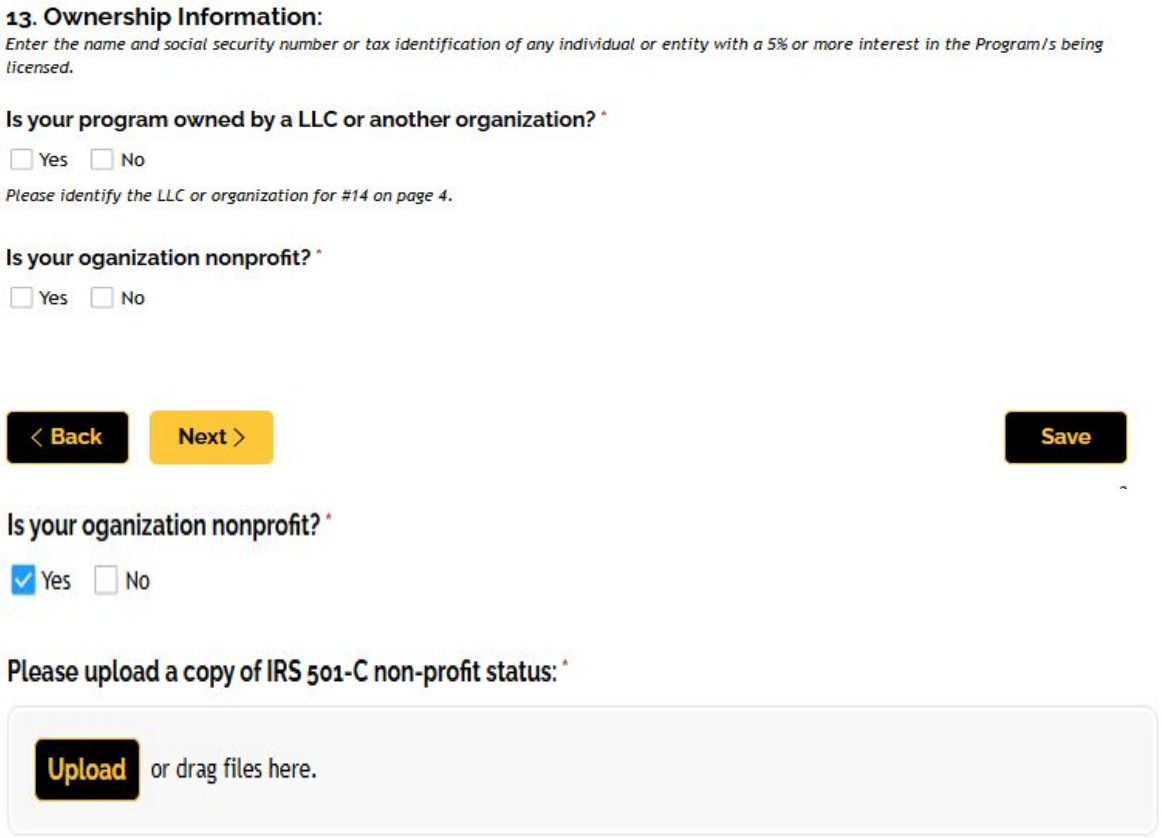
Part A: Organization Information- Corporate Structure



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.

Is your program owned by a LLC or another organization? *

☐ Yes ☐ No

Please identify the LLC or organization for #14 on page 4.

Is your oganization nonprofit? *

☐ Yes ☐ No

< Back | Next > | Save

Is your oganization nonprofit? *

☑ Yes ☐ No

Please upload a copy of IRS 501-C non-profit status: *

Upload or drag files here.

Question 13

- This section of the application is where you will enter your corporate structure information to include:
  - Identification of owner(s)
  - Identification if your agency holds nonprofit status
    - if you are a nonprofit you will be required to upload your 501-c non-profit documentation

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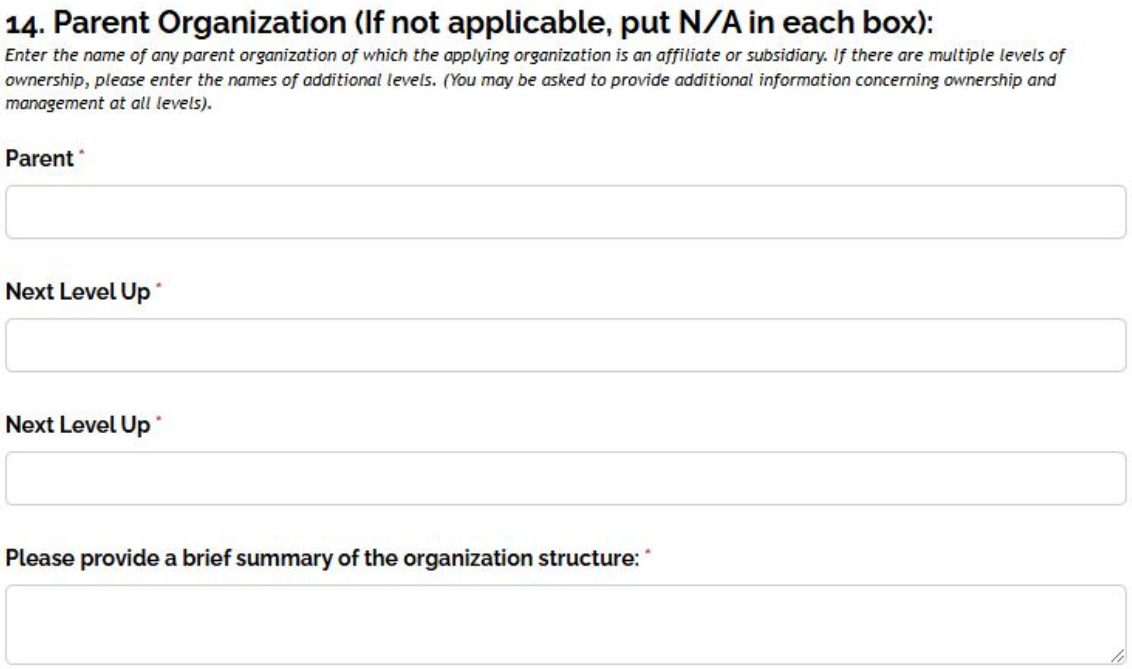
Part A: Organization Information- Corporate Structure Information



14. Parent Organization (If not applicable, put N/A in each box):

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 *

Please provide a brief summary of the organization structure: *

Question 14

- If your program is a part of a larger organization you will enter the parent organization in this section .
  - 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.
  - Please also provide a brief summary of the organization structure(You may be asked to provide additional information concerning ownership and management at all levels).
  - If any field does not apply, please enter n/a in each field.

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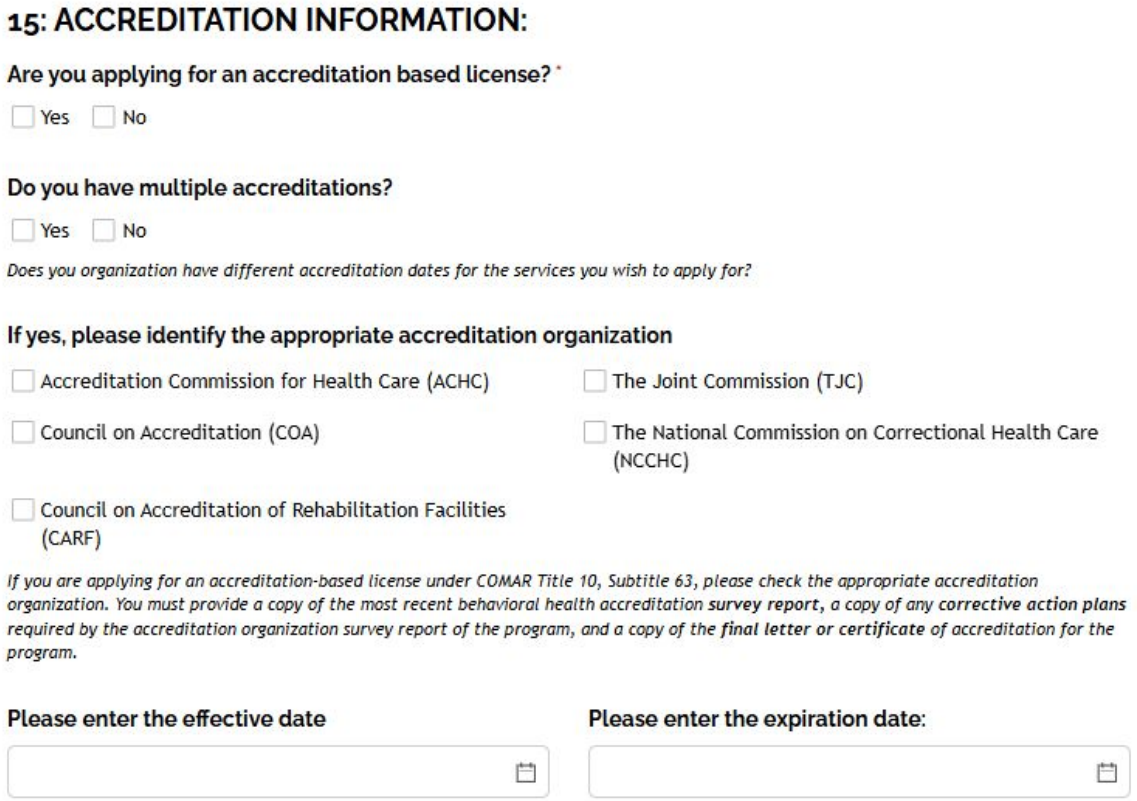
Part A: Organization Information- Accreditation Information



15: ACCREDITATION INFORMATION:

Are you applying for an accreditation based license? *

☐ Yes ☐ No

Do you have multiple accreditations?

☐ Yes ☐ No

Does you organization have different accreditation dates for the services you wish to apply for?

If yes, please identify the appropriate accreditation organization

☐ Accreditation Commission for Health Care (ACHC)

☐ The Joint Commission (TJC)

☐ Council on Accreditation (COA)

☐ The National Commission on Correctional Health Care (NCCHC)

☐ Council on Accreditation of Rehabilitation Facilities (CARF)

*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.*

Please enter the effective date

Please enter the expiration date:

Question 15

- In this question you will identify if you are applying for an accreditation based license.
- Identify if you have multiple accreditations (this is for providers who are applying for multiple services and may have different accreditation dates or if you are accredited by multiple accreditation organizations).
- You will enter the accreditation organization effective and expiration date, type of accreditation, and if your organization has a plan of correction/quality improvement.
- **Please note that DUI and Early Intervention do not require an accreditation.**

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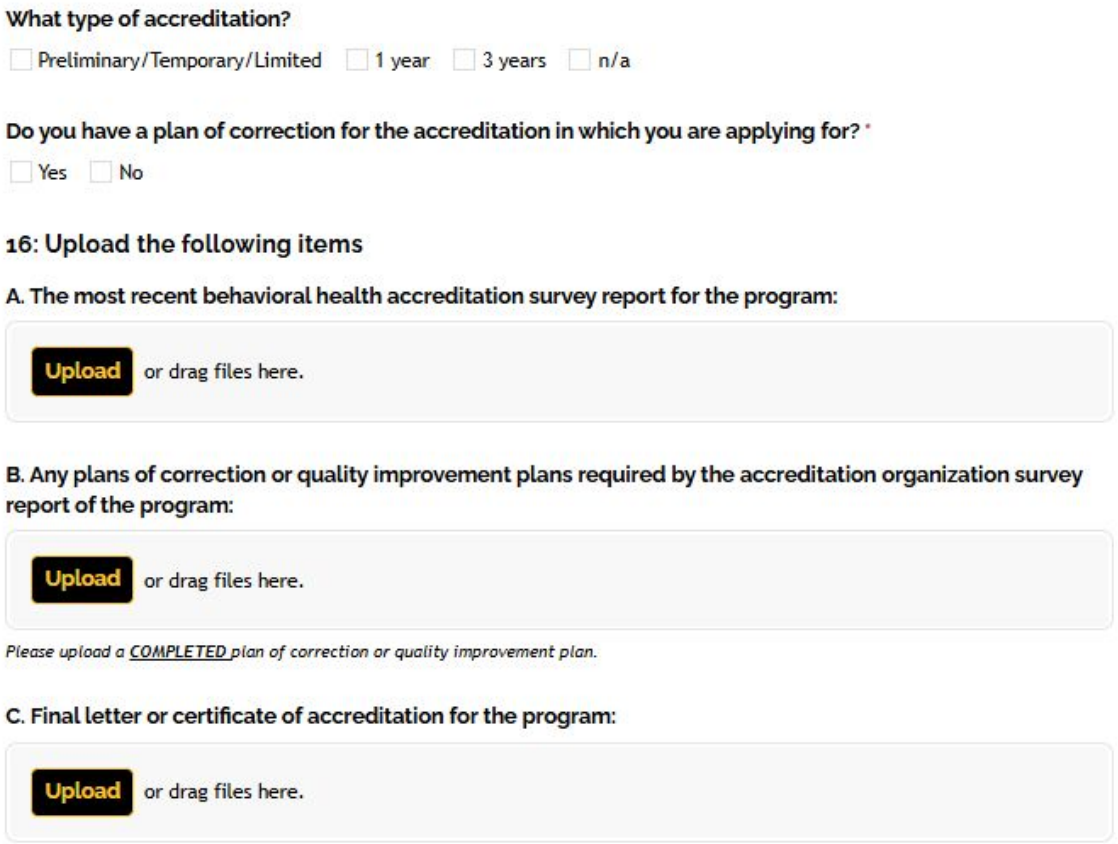
Part A: Organization Information- Accreditation Information



Question 16

- You will upload the following:
  - The most recent behavioral health accreditation survey report for the program
  - Any plans of correction or quality improvement plans required by the accreditation organization survey report of the program.
    - Please ensure you are uploading a COMPLETED plan of correction or quality improvement plan.
    - If you do not have a quality improvement plan or corrective action plan, please upload supporting documentation to reflect this.
  - The Final letter or certificate of accreditation for the program.

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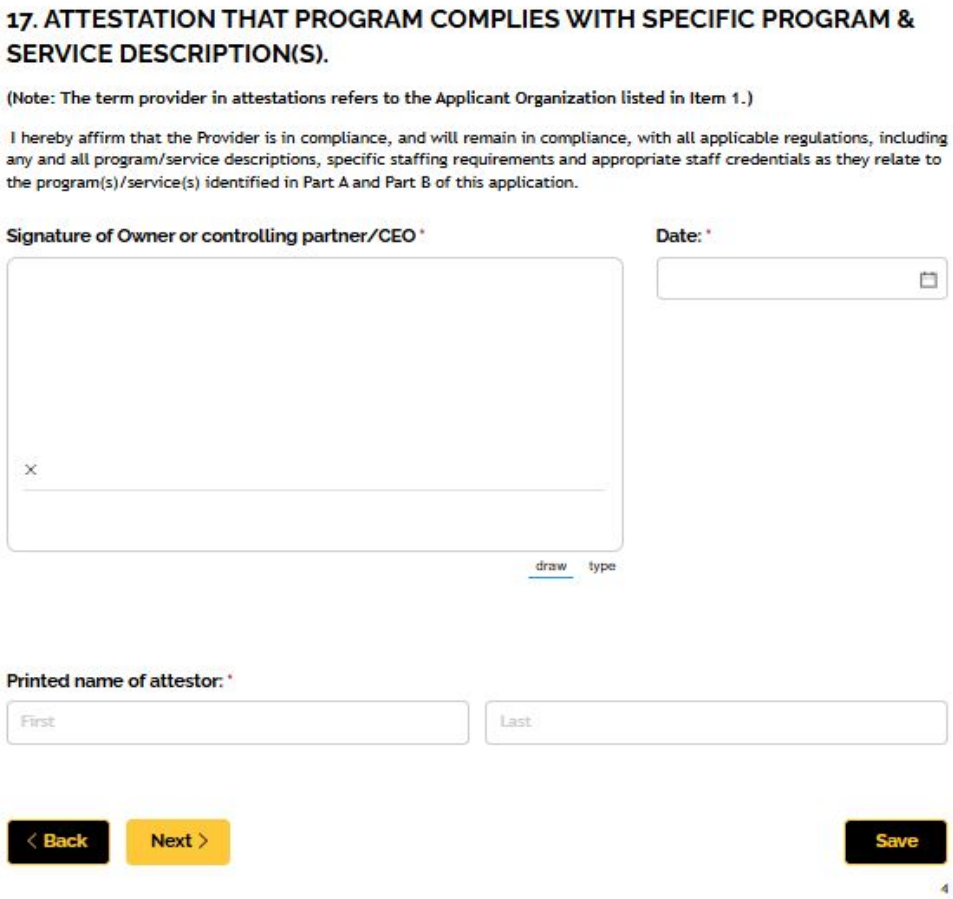
Part A: Organization Information- Attestation of Compliance


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: *

draw type

Printed name of attestor: *

First

Last

Back

Next

Save

Question 17

- This is the attestation that the program complies with specific program & service descriptions.
- Please read carefully, sign, date and print the name of the attestor.

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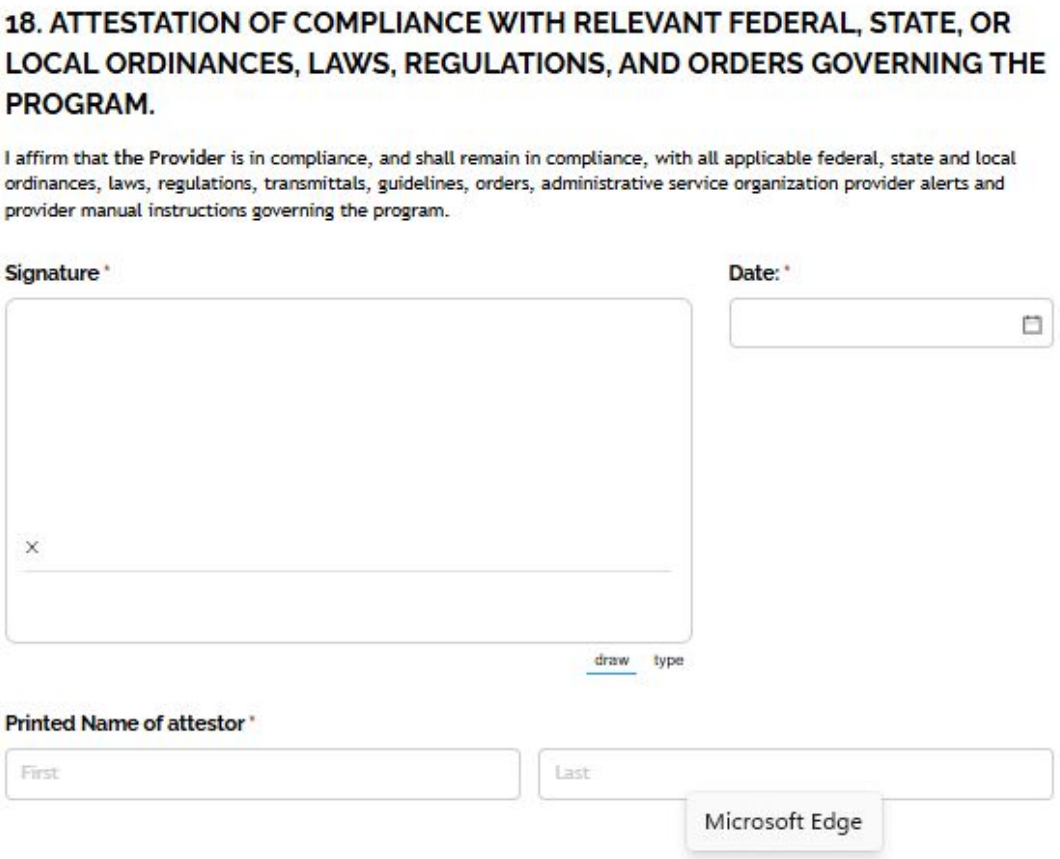
Part A: Organization Information- Attestation of Compliance



Question 18

- The attestation of compliance with relevant federal, state, or local ordinances, laws,regulations, and orders governing the program.
- Please read carefully, sign, date and print the name of the attestor.

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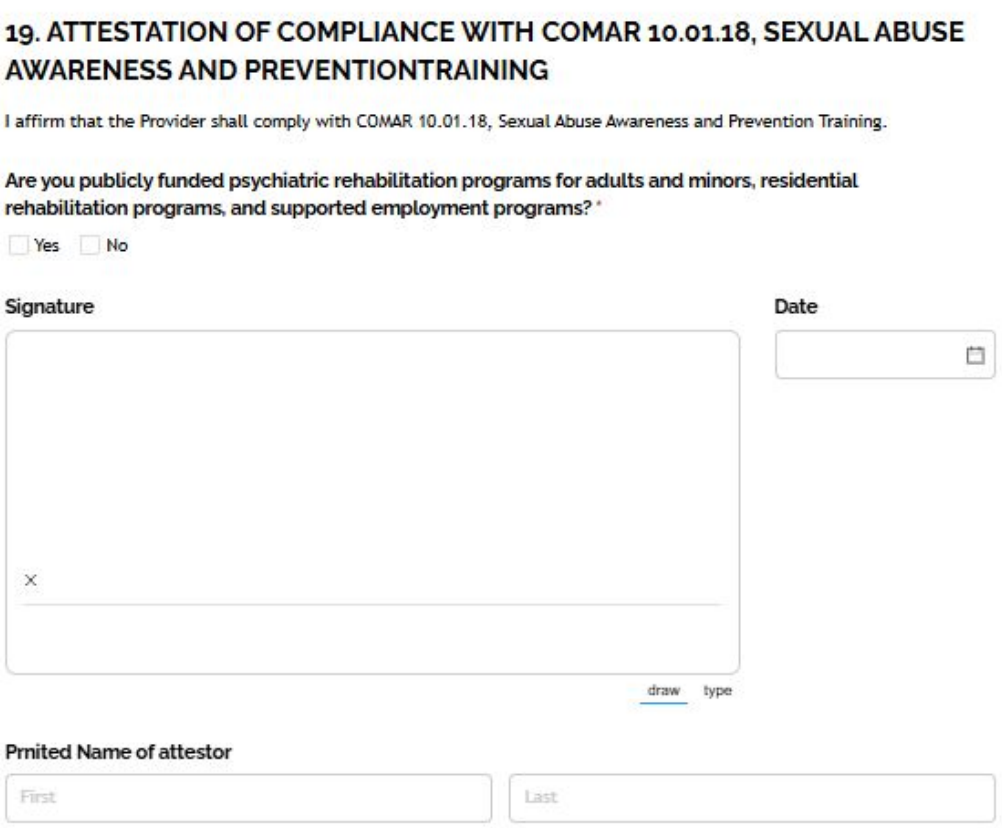
Part A: Organization Information- Attestation Sexual Abuse Awareness Prevention Training



19. ATTESTATION OF COMPLIANCE WITH COMAR 10.01.18, SEXUAL ABUSE AWARENESS AND PREVENTIONTRAINING

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

Are you publicly funded psychiatric rehabilitation programs for adults and minors, residential rehabilitation programs, and supported employment programs? *

Yes No

Signature

Date

draw type

Prnited Name of attestor

First Last

Question 19

- The next attestation, question 19 is the attestation of compliance with COMAR 10.01.18, sexual abuse awareness and prevention training.
- Please read carefully and identify if you are publicly funded psychiatric rehabilitation programs for adults and minors, residential rehabilitation programs, and supported employment programs.
    - If yes, please sign, date and print the name of the attestor

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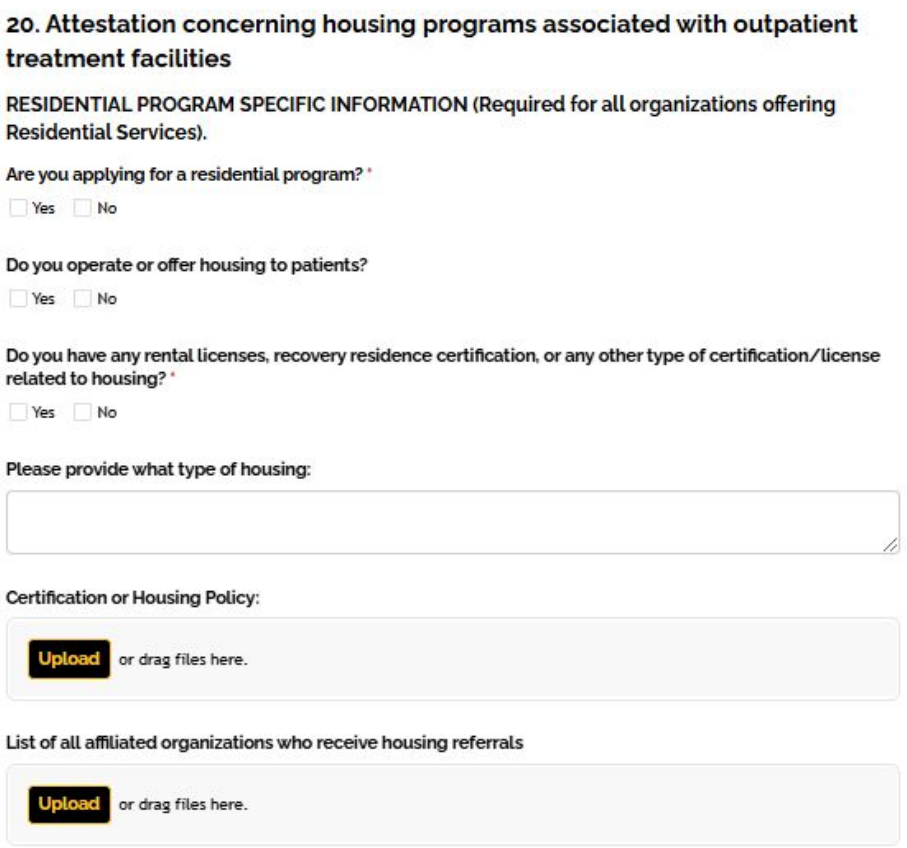
Part A: Organization Information- Attestation regarding housing



20. Attestation concerning housing programs associated with outpatient treatment facilities

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

Are you applying for a residential program? *

Yes No

Do you operate or offer housing to patients?

Yes No

Do you have any rental licenses, recovery residence certification, or any other type of certification/license related to housing? *

Yes No

Please provide what type of housing:

Certification or Housing Policy:

Upload or drag files here.

List of all affiliated organizations who receive housing referrals

Upload or drag files here.

- Question 20 are attestations concerning housing programs associated with outpatient treatment facilities.
  - Identify if you are applying for a residential program
    - If yes, please upload the following:
      - Certification or Housing policy
      - List of all affiliated organizations who receive housing referrals

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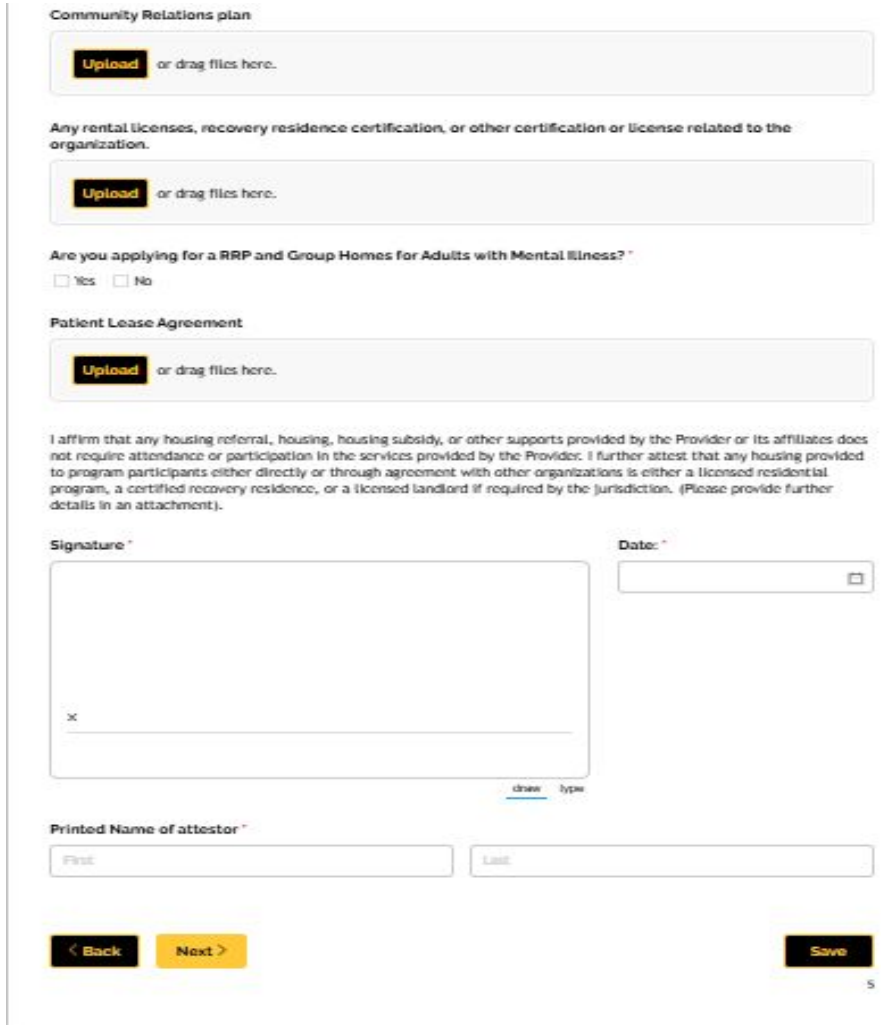
Part A: Organization Information- Additional Housing Information



If you are providing housing services and selected yes, you will upload:

- Community Relations Plan
- Any rental licenses, recovery residence certification, or other certification or license related to the organization in the correct field.

Identify if you operate or offer housing to patients.

- Then identify if you have any rental licenses, recovery the residence certification, or any other type of certification/license related to housing
  - If yes, please identify the type of housing in the populated field and upload the certification or housing policy.
- Please identify if you are applying for a RRP and Group Homes for Adults with Mental Illness
  - if yes is selected, please upload the patient lease agreement
- Next, please read and sign the housing affirmation. **<u>This is required for all applicants.</u>**

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Part A: Organization Information- Required Disclosures

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

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.

☐ Yes ☐ No

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

☐ Yes ☐ No

- Question 21 is in regards to the required disclosures.
  - Please answer the following disclosures identified.
    - If you answer yes to any of the disclosures, you are required to explain and provide supporting documentation.

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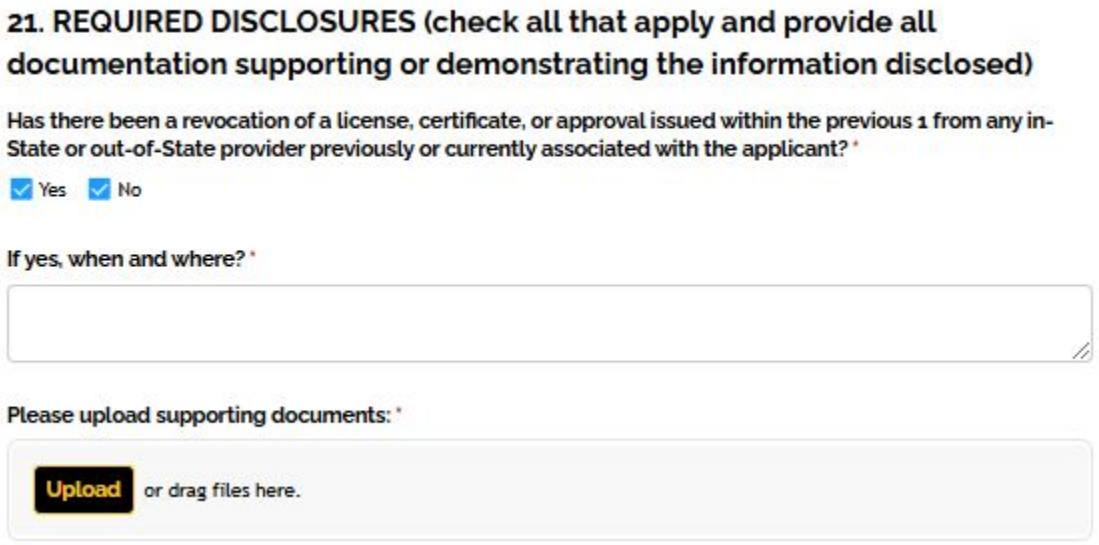
Part A: Organization Information- Required Disclosures



- If you select yes to any of the required disclosures you will be required to submit the following:
  - An explanation to included where and when the occurrence took place
  - Upload any associated documentation to the occurrence

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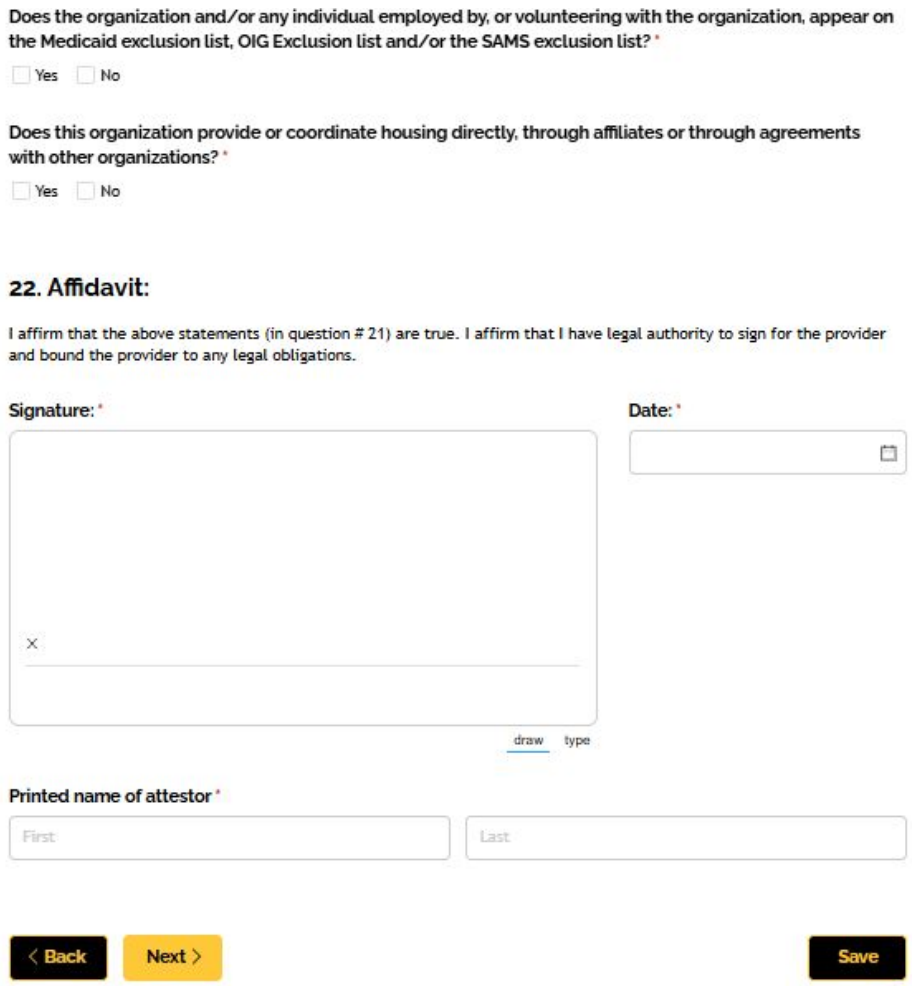
Part A: Organization Information- Required Disclosures



- Question 21 is in regards to the required disclosures.
  - Please answer the following disclosures identified.
    - If you answer yes to any of the disclosures, you are required to explain and provide supporting documentation.

- Question 22 is the affidavit for the required disclosures. Please read carefully, sign, date, and print name of attestor.

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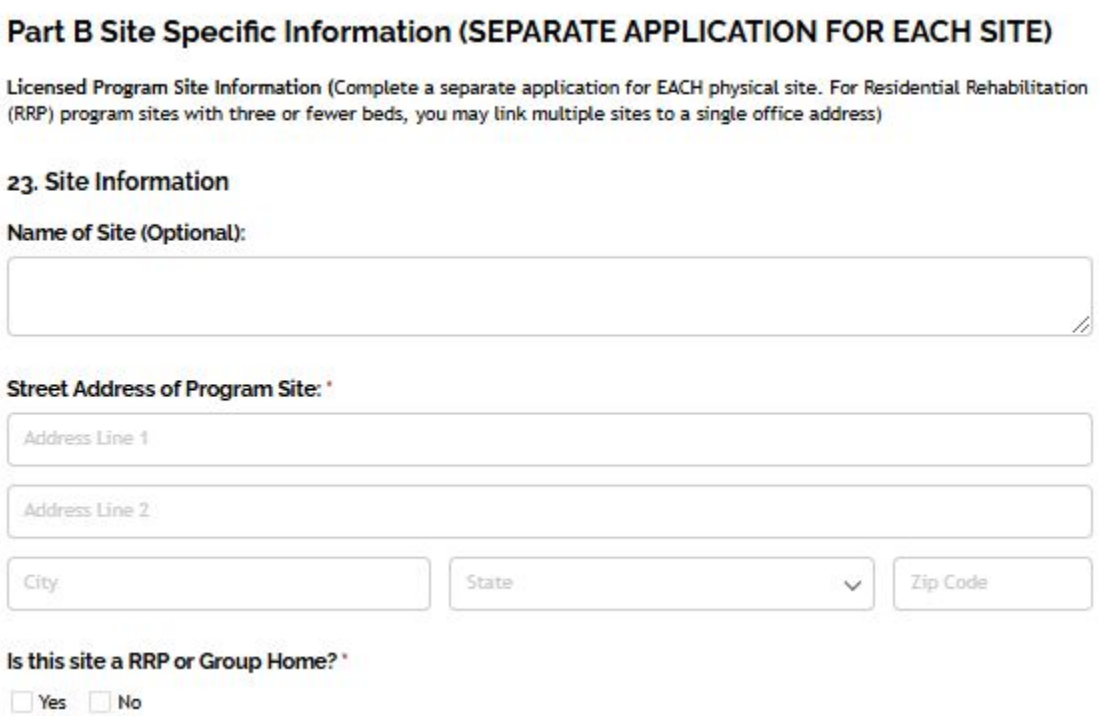
Part B Site Specific Information



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

Licensed Program Site Information (Complete a separate 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)

23. Site Information

Name of Site (Optional):

Street Address of Program Site: *

Address Line 1

Address Line 2

City | State | Zip Code

Is this site a RRP or Group Home? *

Yes No

- Question 23, please identify the site information including:
  - The name of the site (optional). If there is no name, please put n/a.
  - Street address of program including city, state and zip code.
  - Identify if the program is a RRP or group home.
    - If identified as a RRP or group home, please identify the physical address for sites with 3 beds or less.
    - You may add as many sites as needed for RRP and group homes with 3 or more beds.

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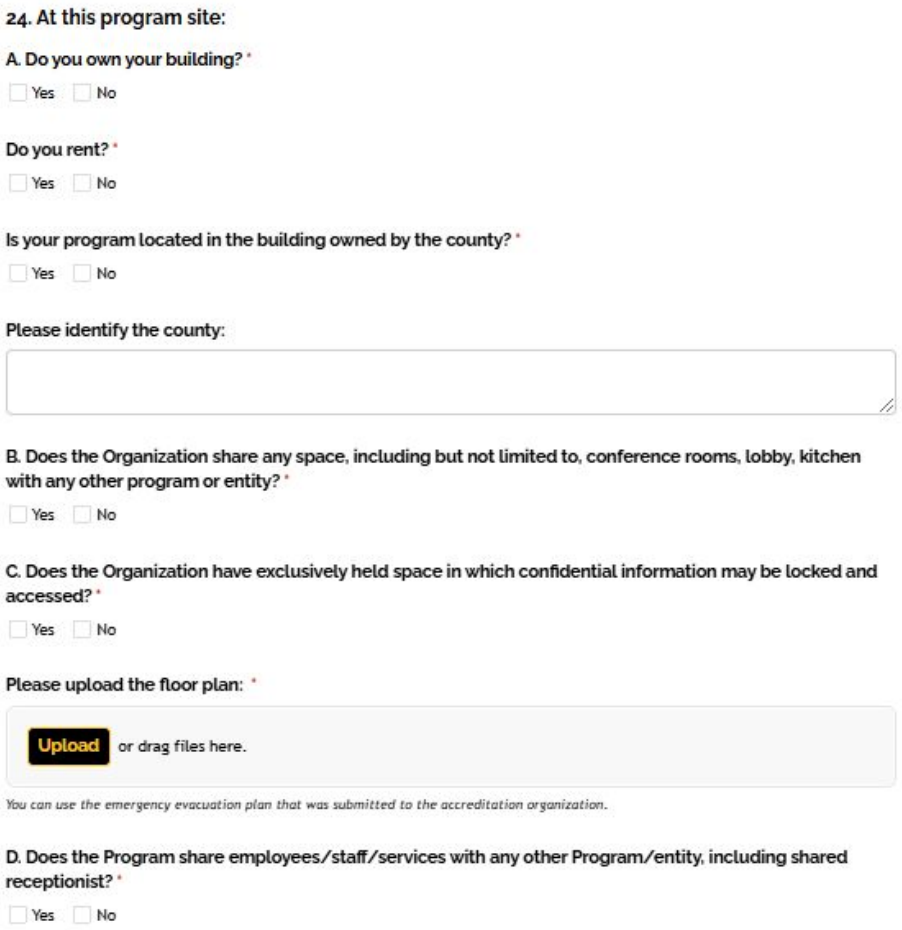
Part B Site Specific Information



24. At this program site:

A. Do you own your building? *

Yes No

Do you rent? *

Yes No

Is your program located in the building owned by the county? *

Yes No

Please identify the county:

B. Does the Organization share any space, including but not limited to, conference rooms, lobby, kitchen with any other program or entity? *

Yes No

C. Does the Organization have exclusively held space in which confidential information may be locked and accessed? *

Yes No

Please upload the floor plan: *

Upload or drag files here.

You can use the emergency evacuation plan that was submitted to the accreditation organization.

D. Does the Program share employees/staff/services with any other Program/entity, including shared receptionist? *

Yes No

- Question 24:
  - You will provide specific site information including:
    - lease or deed
    - Whether the program is in an government owned building
    - If your program share space with other organizations.
    - Private, locked and confidential space for records
    - Upload a floor plan
      - *You can use the emergency evacuation plan that was submitted to the accreditation organization.*
    - Identify any shared employees, staff, and/or services.

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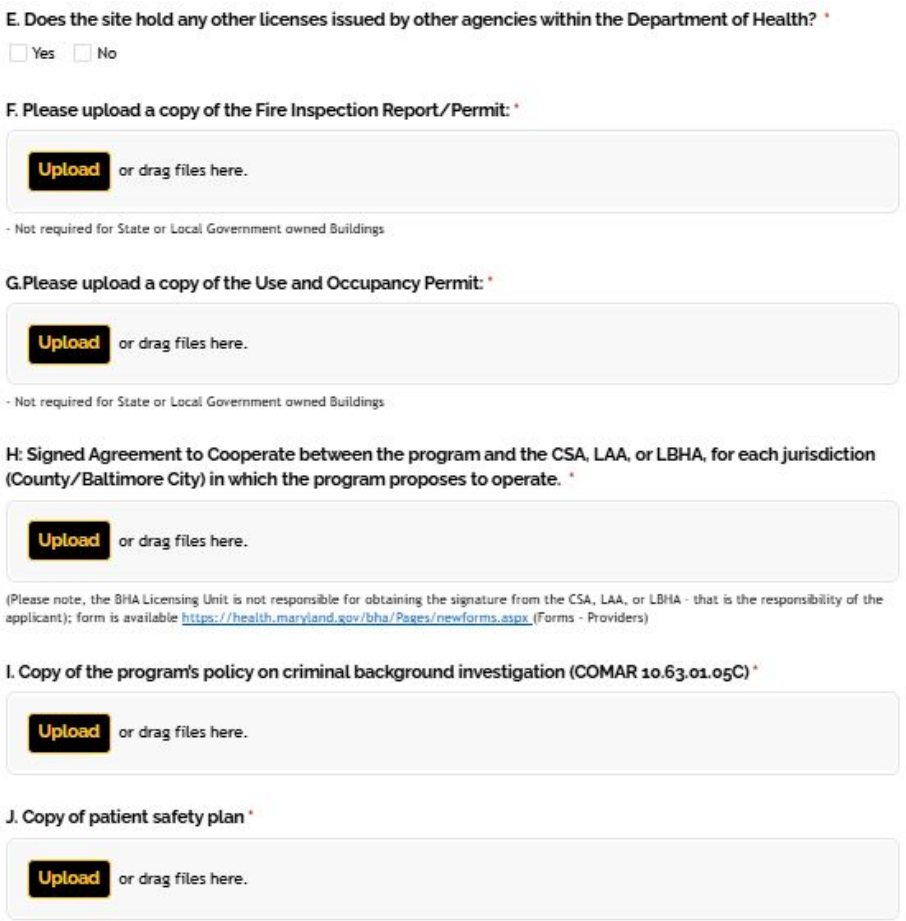
Part B Site Specific Information


E. Does the site hold any other licenses issued by other agencies within the Department of Health? *

Yes No

F. Please upload a copy of the Fire Inspection Report/Permit: *

Upload or drag files here.

- Not required for State or Local Government owned Buildings

G.Please upload a copy of the Use and Occupancy Permit: *

Upload or drag files here.

- Not required for State or Local Government owned Buildings

H: 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. *

Upload or drag files here.

(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)

I. Copy of the program's policy on criminal background investigation (COMAR 10.63.01.05C) *

Upload or drag files here.

J. Copy of patient safety plan *

Upload or drag files here.

Question 24 Continued

- Identify if the program has other licenses from agencies in MDH
- Upload the required documentation. **This is for all programs!**
  - Fire inspection report (within 12 months of date of application)
  - Use and Occupancy
  - Signed Agreement to Cooperate
  - Criminal Background Policy
  - Safety Plan

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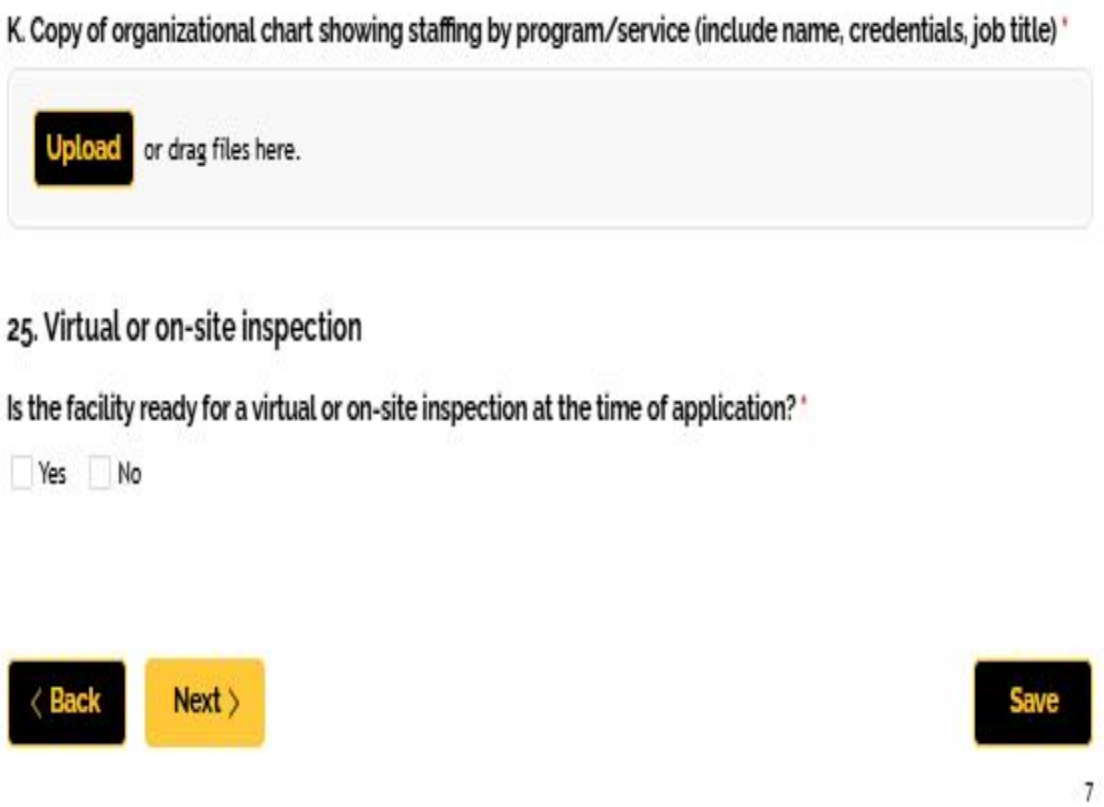
Part B Site Specific Information



- Question 24 Continued
  - Upload the required documentation. **This is for all programs!**
    - Organizational Chart
- Question 25
  - Identify if your program is ready for an onsite or virtual inspection.
    - If no, please identify the date when your program will be ready.

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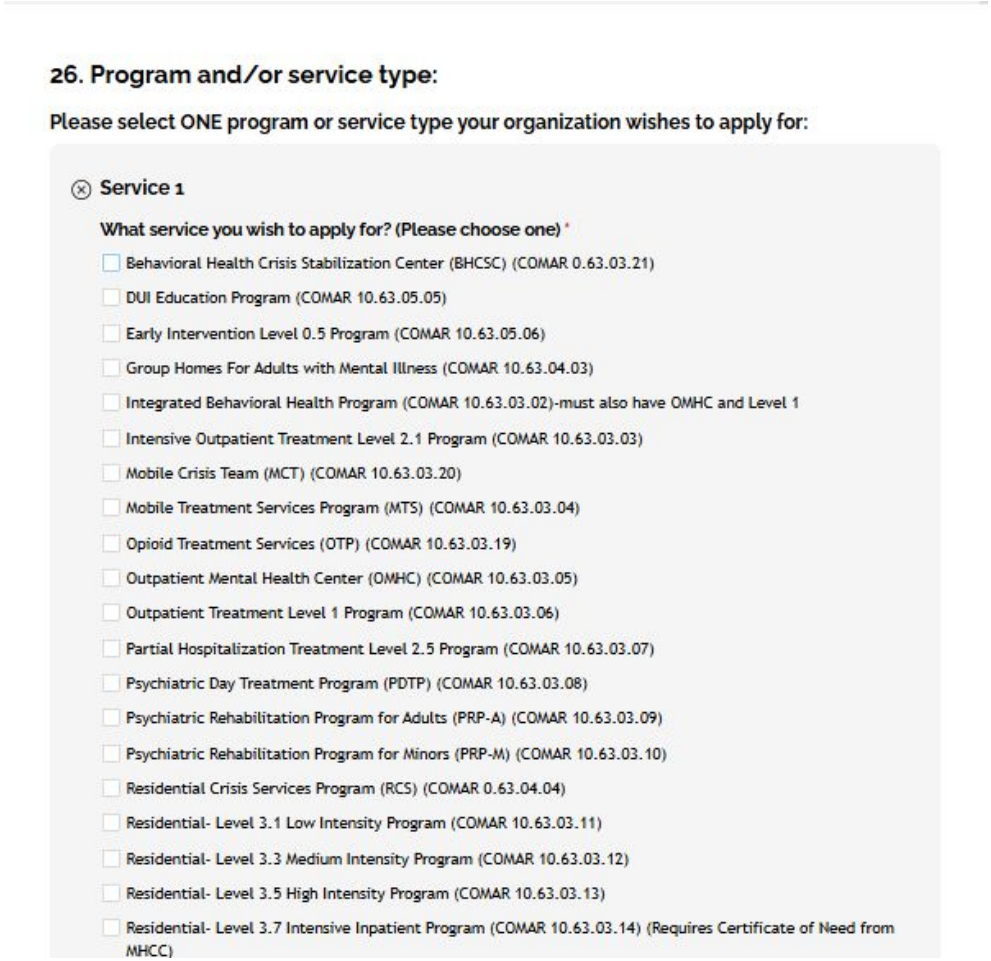
Part B Site Specific Information- Service Selection



26. Program and/or service type:

Please select ONE program or service type your organization wishes to apply for:

⊗ **Service 1**

What service you wish to apply for? (Please choose one) *

- ☐ 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 0.63.04.04)
- ☐ 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)

- Question 26: Program and/or service type
  - Please select only **ONE** service type at a time.
  - You will be able to add services once the affidavit for the selected service is completed.

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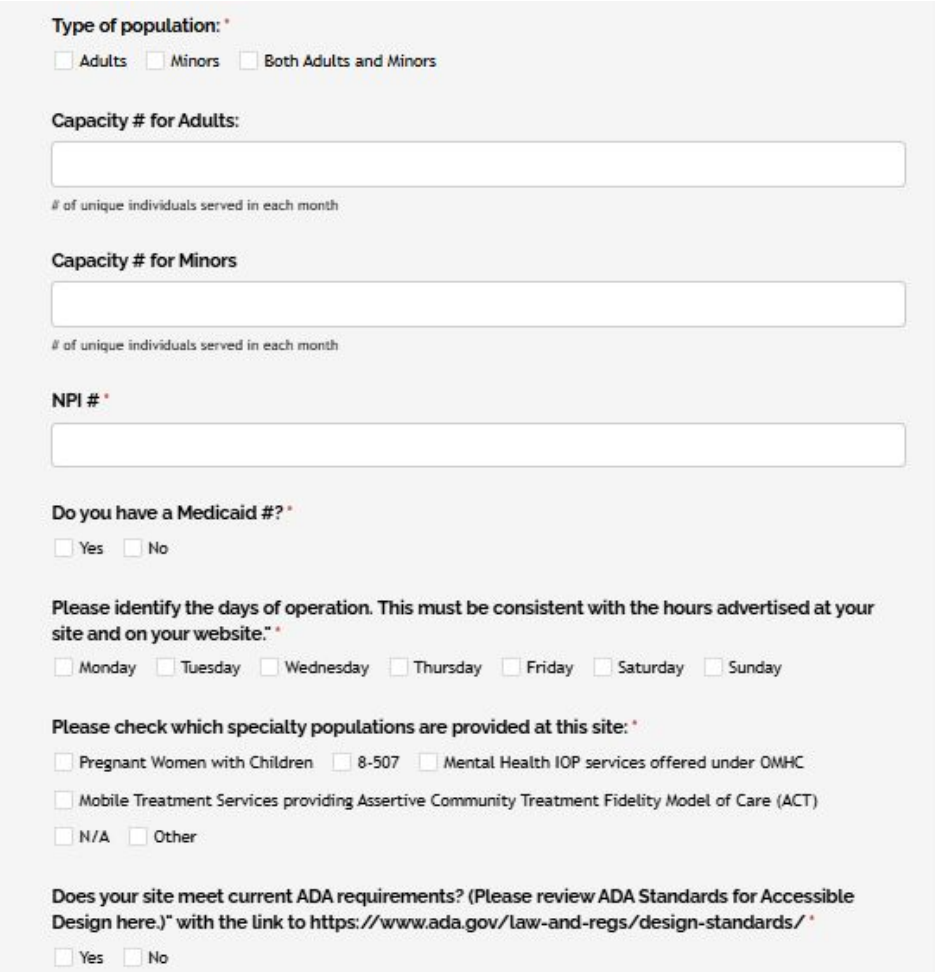
Part B Site Specific Information- Service Selection



Type of population: *

Adults Minors Both Adults and Minors

Capacity # for Adults:

# of unique individuals served in each month

Capacity # for Minors

# of unique individuals served in each month

NPI # *

Do you have a Medicaid #? *

Yes No

Please identify the days of operation. This must be consistent with the hours advertised at your site and on your website." *

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

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)

N/A Other

Does your site meet current ADA requirements? (Please review ADA Standards for Accessible Design here.)" with the link to https://www.ada.gov/law-and-regs/design-standards/ *

Yes No

- Identify the following(please ensure the information reflects the service you selected):
  - Type of population
  - capacity of individuals you wish to serve.
  - NPI #
  - If you have a medicaid #
  - The days of operation
  - Speciality population served (if applicable)
  - If your site is ADA compliant

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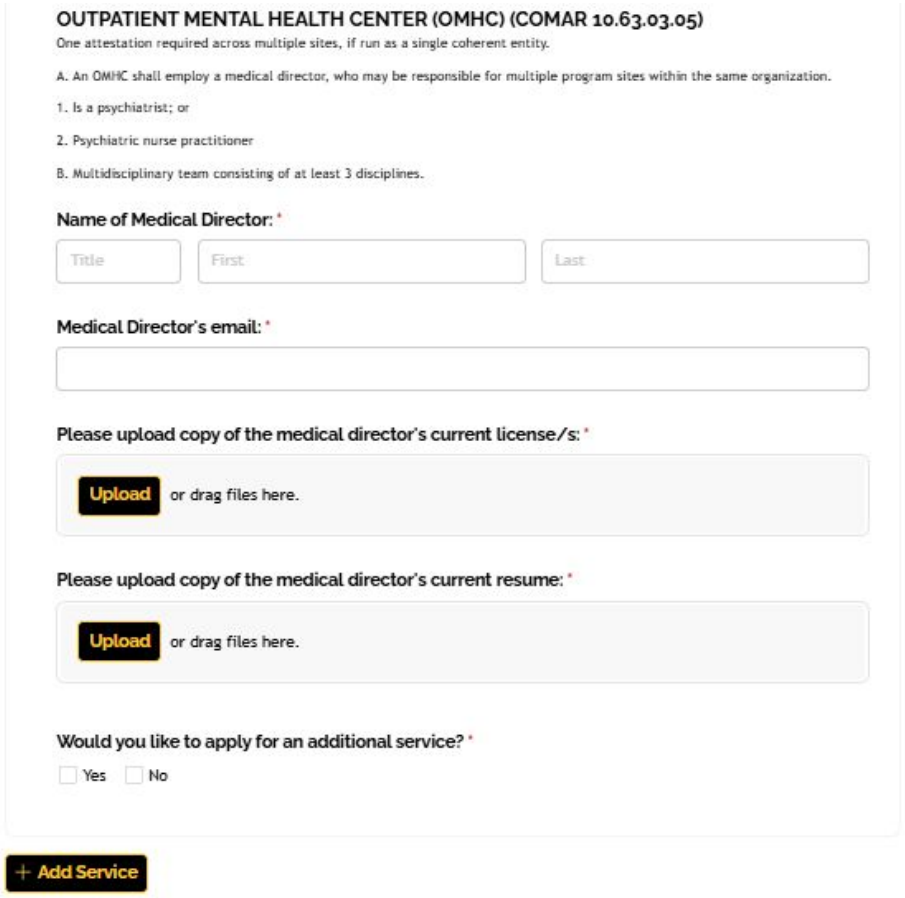
Part B Site Specific Information- Services Selection required staff



- Affidavits related to the service you are applying for will populate.
- Please ensure you are filling out the entire affidavit and uploading the required documents.
    - Please ensure the email of the required staff is correct.

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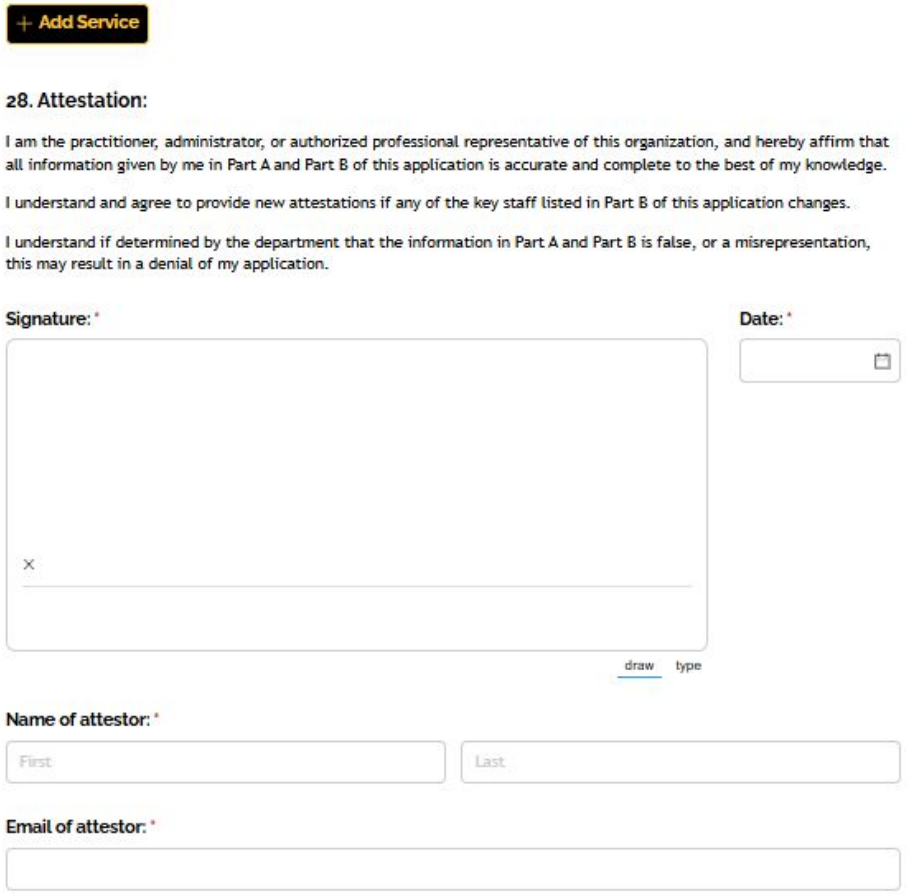
Part B Site Specific Information- Final Attestation



- This is the final attestation.
- The practitioner, administrator, or authorized professional representative will read, sign, and date.

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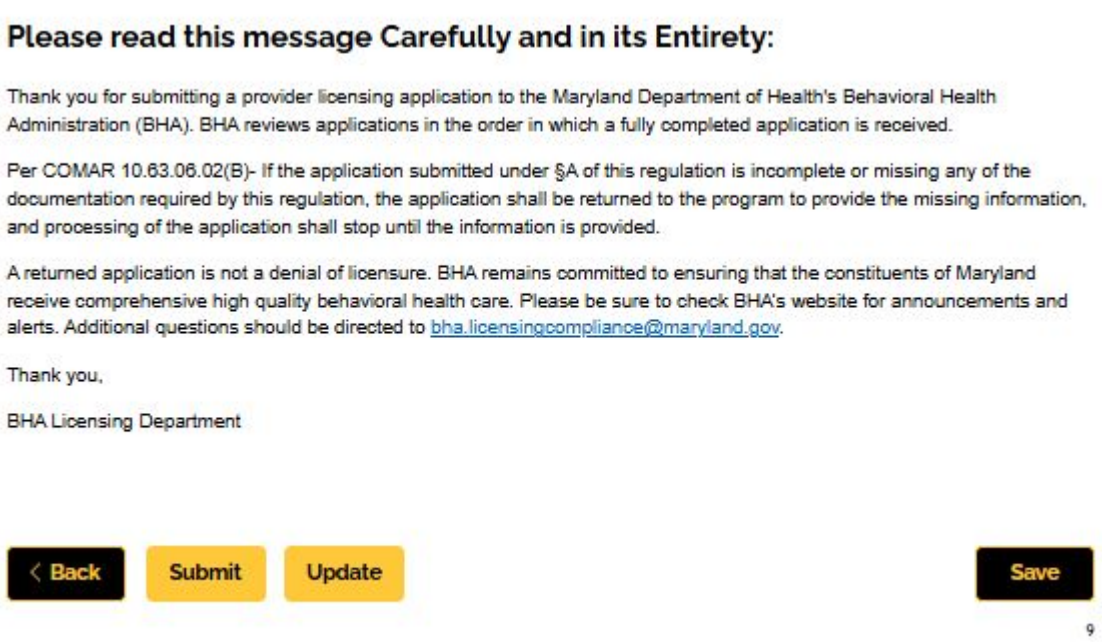
Application Submission



Please read this message Carefully and in its Entirety:

Thank you for submitting a provider licensing application to the Maryland Department of Health's Behavioral Health Administration (BHA). BHA reviews applications in the order in which a fully completed application is received.

Per COMAR 10.63.06.02(B)- If the application submitted under §A of this regulation is incomplete or missing any of the documentation required by this regulation, the application shall be returned to the program to provide the missing information, and processing of the application shall stop until the information is provided.

A returned application is not a denial of licensure. BHA remains committed to ensuring that the constituents of Maryland receive comprehensive high quality behavioral health care. Please be sure to check BHA's website for announcements and alerts. Additional questions should be directed to bha.licensingcompliance@maryland.gov.

Thank you,

BHA Licensing Department

< Back | Submit | Update | Save

9

- This is the final page before submission.
- Please read this message carefully and its entirety.
- Once read, you may either save the document before submitting or you may submit the application.

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Questions

Please contact the Office of Licensing and Compliance at:

email: bha.licensingcompliance@maryland.gov

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Resources

- Behavioral Health Administration (BHA) website
- Regulation COMAR 10.63
- Maryland Medicaid Provider Enrollment
- Maryland Department of Labor website
- Maryland Statute
- State Department of Taxation and Assessment website (SDAT)
- Board of Professional Counselors and Therapists
- Board of Social Work Examiners
- Board of Nursing
- Board of Physicians
- Board of Examiners of Psychologists

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