MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Behavioral Health Administration
Lisa A. Burgess, M.D.
(Acting) Deputy Secretary/Executive Director
55 Wade Ave., Dix Bldg., SGHC
Catonsville, MD 21228

APPLICATION FOR A RECOVERY RESIDENCE CERTIFICATE OF COMPLIANCE

IMPORTANT: PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

In accordance with HB 1411, all residential facilities considered as "recovery residences" must receive a certificate of compliance from the Maryland Behavioral Health Administration on or before October 1, 2017. Enclosed you will find an application which must be completed by any applicant seeking a certificate of compliance for a recovery residence.

"**Recovery Residence"** means a service that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders or addictive disorders or co-occurring mental health substance-related, or addictive disorders. Recovery residences provide Marylanders housing in a safe and healthy environment that supports residents in initiating and sustaining their recovery. Recovery residences, though, formal and informal peer support, empower, strengthen, and sustain the emergent healthy lifestyles of residents as they transition toward independent and productive lives in their respective communities.

Before applying for certification, please review the Documentation Checklist on BHA's website https://bha.health.maryland.gov/Pages/Recovery-Residences.aspx to identify documentation requirements. **A separate application is required for each service site location.**

Please type or print legibly all required information. Failure to fill in required information or provide supporting documentation will delay the application being processed until all required information is received. Please retain a copy of the application and attachments for your files.

Return Completed Application to: Mail: Maryland Certification of Recovery Residences
Behavioral Health Administration
Hill Building
55 Wade Avenue
Catonsville, MD 21228
Email: mcorr.info@maryland.gov
Fax: (410)402-8732

Should you have any questions, please contact the Behavioral Health Administration (BHA) at (410) 402-8595.

Certification of Recovery Residences Application

A Certificate of Compliance is issued once your application is approved and the recovery residence has passed a site inspection conducted by the Behavioral Health Administration (BHA) or a contractor approved by BHA. **The certification is valid for one (1) year from the date of issuance.** Each applicant is required to submit additional documents to accompany this application. Please refer to the Documentation Checklist for a list of required documents.

Please select the type of application your organization would like to apply for:

Application Type:

☐Initial Certification

☐ Application Change
- _ Ownership
- _ Location
- _ Gender
- _ Bed Capacity
- _ Level of Support

☐Renewal Certification (Cert#_____)

Please review the list below and attach copies of the following documents. All documents are required and applications are not considered complete if the documents are not submitted with this application.

Checklist:

_____ Proof of Property Ownership/Letter from Property Owner
_____ Certificate of Insurance
_____ Policy and Procedure Manual
_____ Proof of Legal Business Entity
_____ Attach MCORR Level Documentation Checklist(see website)
_____ Staff Credentials (Level III and IV)
_____Resident Orientation Handbook
_____Fire and Safety Inspection Report **(Residence with more than 5 occupants and a house manager) or Affidavit of compliance (Residence with 5 occupants or less and a house manager)**

I. Applicant Information: (Required) The business name of the organization must be listed as it is registered with Maryland State Department of Assessment and Taxation.	
Organization(Full Name):	Legal Entity(Full Name):
Type of Organization: ☐Sole Proprietor ☐Partnership ☐C-Corporation ☐S-Corporation ☐Limited Liability Company	Website:
Mailing Address: (City, State, Zip Code)	Program Email: Tax ID:
Main Office Phone Number:	Fax Number:
Owner's Name and Contact Number:	
Owner's Email Address:	
Program's Contact Number:	
Program's Email Number:	

1. Has the organization received any funding from the State of Maryland to support this service? If so, please list the following:

Funding Type:_____ MDRN/ATR ___Contract w/County or City government

_____Other_____

(Check all that apply)

When? ____ 2019 ___2018 ____ 2017 ___2016 ___2015 ___2014

2. Maryland Certification of Recovery Residences (MCORR) values and encourages partnerships with Faith and Community –based organizations.

MCORR defines a Faith–Based Organization as:

- a religious congregation (church, mosque, synagogue, or temple) or,
- an organization, program, or project sponsored/hosted by a religious congregation (may be incorporated or not incorporated) or,
- a nonprofit organization founded by a religious congregation or religiously-motivated incorporators and board members that clearly states in its name, or incorporation, or mission statement that it is a religiously motivated institution or,
- a collaboration of organizations that clearly and explicitly includes organizations from the previously described categories.

(Faith Organization founded on a particular religion or spiritual belief)

Religious denomination: _____

Place a check mark in the box that best describes your organization.

☐ Community-Based
☐ Non-profit
☐ For- profit
☐ Grassroots (annual operating budget of $500,000 or less)
☐ Other: _____

II. Staffing Information:

1. Organization's Director(include Title):

Email:
Phone:

Emergency Contact Person:

Email:
Phone:

2. **House Manager(Full Name)**:

Email:

Phone:

Is the House Manager compensated for job duties? If yes please check:

☐ free/partial room and board

☐ paid salary ☐ Other:_____

Does the house manager live in this residence?

Hours on Duty:_____

III. Property Information	
Property Name:	**Property Ownership**: ☐owns property ☐leases from 3rd party ☐leases from related person entity
Levels of Support(choose one): ☐I Peer Run ☐II Monitored ☐III Supervised ☐IV Service Provider	**Type of Structure**: ☐Single family ☐Multi-unit dwelling/apt.(#units_____) ☐Facility Is this residence handicap accessible? _Y _N If yes, please describe:
Physical/Service Address: (City, State, Zip Code) **County**:	**#Bedrooms** **(50 sq ft per bed per sleeping room)** ☐1 ☐2 ☐3 ☐4 ☐Other:____
Billing Address: (City, State, Zip Code)	**#Bathrooms** **(1 full bath required for every (6) residents)** ☐1 ☐2 ☐3 ☐4 ☐Other:____

Special Services: (check all that apply) ☐offers American Sign Language interpretation ☐is universally accessible for individuals with disabilities ☐has a location near public transportation ☐has handicapped parking ☐ offers service in languages other than English (If so, what language(s)?)	**Bed Capacity: ___** **(#number of residents only <u>without</u> house manager)**

IV. Population Served

Please choose one:

☐Women
☐Men
☐Co-ed

Other:

☐Women with Children
☐LGBT
☐Veterans
☐Pregnant Women
☐Transitional Aged Youth

1. Is your organization abstinence based? ☐Yes ☐No
2. Does your organization accept individuals receiving medication assisted treatment? ☐Yes ☐No
3. Does your organization conduct routine drug testing? ☐Yes ☐No
4. Do you have a program that provides substance use or mental health services? ☐Yes ☐No
   Please specify program:

V. Resident Fees. ***(In this section, please indicate how often resident fees are collected, and select room type).***

Billing Frequency (how often resident fees is collected): ☐weekly ☐bi-weekly ☐monthly
Administrative Fees:_____
Security deposit amount:_____
Prorated amount:_____
First and Last Amount:_____

Room Type:
- ☐ Shared room amount:_____
- ☐ Private room amount:_____

1. Is food included in the fees charged? If yes, how much?_____ ☐Yes ☐No
2. Who manages the residents' funds?_____

VI. Disclosures: (Required)
Complete **only** if your organization is not licensed or certified by, registered with, or otherwise accredited by or affiliated with an authority accepted by the Maryland Department of Health and Mental Hygiene, consistent with the qualification requirements of the Maryland Certification of Recovery Residences.

Has a prior license, certification, or approval issued within the previous five (5) years from any in-State or out-of-State provider previously or currently associated with your organization been revoked or surrendered?

☐Yes

☐No

If yes, please explain and provide a copy of any associated deficiency or compliance reports.

Has your organization or a program, corporation, or provider previously or currently associated with your organization surrendered or defaulted on its license, certification, or approval within the previous five (5) years for reasons related to disciplinary action?

☐Yes

☐No

If yes, please explain the nature of the disciplinary conduct.

Has any employee, staff, peers, or volunteer currently associated with your organization had a professional license or certification revoked or suspended or surrendered a professional license or certification for reasons related to disciplinary action or misconduct, within the previous ten (10) years.

☐Yes, full name and date of birth of individual

☐No

If yes, please explain the nature of the disciplinary action or conduct

Has any employee, staff, peer, or volunteer currently associated with your organization been convicted of a felony within the previous ten (10) years?

☐Yes Full name and date of birth of individual

☐No

If yes, please explain the nature of the disciplinary action or conduct.

Terms of Agreement Acknowledgement

By signing below, I certify that I have read and understand the Maryland Certification of Recovery Residences requirements. I have read and agree to comply with the National Association of Recovery Residences (NARR) standards and the Code of Ethics. I agree to the information provided in this application and attachments are correct and true to my knowledge.

Print Name: _____

_____

Signature of Applicant's Representative Title or Position Date

For Maryland Certification of Recovery Residences office use only:	
Date application received:	o Application approved Decision Date:
MCORR Director/Manager's Signature:	o Application denied Reason:

Revised: May 22, 2019