Maryland
DEPARTMENT OF HEALTH

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 "certified 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 Marylander's housing in a safe and healthy environment that supports residents in initiating and sustaining their recovery. Recovery residences, through 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.

"**Staff member** "means any individual who is employed by a recovery residence or a covered program, whether contractually or permanently, and any individual who volunteers with, is a contractor for, or consultant to, works as an intern for, serves in a peer role for, or otherwise is engaged by the recovery residence or any program, partnership, corporation, or entity associated with the recovery residence to provide administrative, programmatic, or support services for or in the interest of the recovery residence.

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 process until all required information has been 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)402-8301

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

☐Renewal Certification (Cert#_____)

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

Please review the list below and attach copies of the following required documents to the application. An application is not considered complete until all the documents listed below have been received.

Checklist:

_____ Proof of Property Ownership/Letter from Property Owner

_____Certificate of Liability 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
_____ Affidavit of Compliance

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:	

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

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

___ Federal Dollars ___Other State Agencies (please list agency) _____

_____Other_____

(Check all that apply)

When? ____ 2020 ____ 2019 ___2018 ____ 2017 ___2016 ___2015 ___2014

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
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, excluding the house manager)**

IV. Population Served

Please choose one:

☐Women

☐Men

☐Co-ed

_____

Other:

☐Women with Children

☐LGBTQI

☐Veterans

☐Pregnant Women

☐Transition Age Youth

☐Criminal justice re-entry

1. Does your program limit the use or dosage of any form of medication (including medication assisted treatment) by individuals residing in your recovery residence?
☐Yes ☐No

If answered yes, please explain:

2. Does your organization provide the safe storage of all medication, including controlled medications on site at the recovery residence? ☐Yes ☐No

3. Does your organization conduct routine drug testing? ☐Yes ☐No

4. Does your program provide substance use and/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)

1. Has your organization had a revocation of a prior license, certificate, or approval issued within the previous 10 years from any in-State or out-of-State agency or provider. Include previous or current organizations associated with the applicant, along with any associated deficiency reports and compliance records.

○ ☐Yes
○ ☐No

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

2. Has your organization or a program, partnership, corporation, or provider previously or currently associated with the applicant, surrendered, or defaulted on its license, certificate, or approval, or had it revoked or suspended within the previous 10 years, for any reason?

☐Yes

☐No

If yes, please explain the reason for the surrender, default, revocation, or suspension *and any disciplinary action?*

3. 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.

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

☐Yes

☐No

If yes, list the identity of any individual or staff member currently associated with the applicant who has had a professional license, certification, or approval revoked or suspended or has surrendered or defaulted on a professional license, certification, or approval for any reason, within the previous 10 years, and the reason for the surrender, default, revocation, or suspension;

5. Has any staff member currently associated with your organization been convicted of a felony, sexual offense, assault, or crime of moral turpitude, within the previous 10 years?

☐Yes

☐No

If yes, please list the identity of any individual or staff member currently associated with the applicant that has been convicted of a felony, sexual offense, assault, or crime of moral turpitude, within the previous 10 years, and the nature of the felony or crime.

6. Has any staff member currently associated with your organization been convicted of child abuse or any child sexual abuse?

☐Yes

☐No

If yes, please list the identity of any individual or staff member associated with your organization who has been convicted of child abuse or any child sexual abuse including date of birth.

7. Has any staff member currently associated with your organization been convicted of abuse or neglect of a vulnerable adult?

☐Yes

☐No

If yes, please list the identity of any individual or staff member associated with your organization who has been convicted of abuse or neglect of a vulnerable adult including date of birth.

8. Has any staff member currently associated been convicted of a felony within the previous ten (10) years?

☐Yes Full name and date of birth of individual: _____

☐No

If yes, please list the identity of any individual or staff member associated with your organization who has been convicted of a felony with the previous ten (10) years including date of birth.

9. Has any staff member currently associated with your organization ever been convicted of a sexual assault, sexual abuse, or second-degree assault?

☐Yes

☐No

If yes, please list the identity of any individual or staff associated with your organization who has been convicted of a sexual assault, sexual abuse or second-degree assault including date of birth.

10. Does any staff member currently associated with your organization have pending charges for a sexual assault?

☐Yes Full name and date of birth of individual: _____

☐No

If yes, please list the identity of any individual or staff member associated with your organization has pending charges for a sexual assault including date of birth.

11. Has your organization or a program, partnership, corporation, or provider previously or currently associated with the applicant, received funding within the previous 5 years from any federal, state, or local governmental entity to support the construction, renovation, maintenance, and operation of a recovery residence?

☐Yes

☐No

If Yes, please list the source of the funding, and the purpose for which the funding was granted.

12. Does your organization or the principals owe money to the Maryland Department of Health or one of its Administrations or any Local Designated Authority?

☐Yes ☐No *If Yes, please list the amount of money owed, and the reason the money is owed.*
13. Provide a listing of any individual who has a 5 percent or more ownership stake in the recovery residence or legal business entity associated with the recovery residence or, if constituted as a non-profit, a listing of the names, percentage of stake in the recovery residence and contact information of all Board members.
14. Provide the names of any other recovery residences or legal business entities associated with a recovery residence or similar program in which the applicant or the principals have, or have had, an ownership interest within the previous 10 years.

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 the information provided in this application and attachments are correct and true to my knowledge.

I understand that providing false or misleading information or failing to disclose requested information may result in a revocation of certification.

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 11, 2021, June 4, 2021