MARYLAND Department of Health
Developmental Disabilities Administration

DDA QUALIFIED SERVICES PROVIDER APPLICATION and PROVIDER RENEWAL

I. Background Information

A. Application is for (check all that apply)

- ☐ An Initial (new) Agency Provider
- ☐ An Initial (new) Individual Provider
- ☐ A Renewal (current provider renewing a license or DDA certification for currently approved services)
- ☐ A currently approved provider seeking approval to add new services
- ☐ Other- please explain_____

B. Services are proposed for

- ☐ Adults (ages 18 and up)
- ☐ Children (aged 17 and under)
- ☐ Both

C. **Applicant's Name or Name of Agency** (attachment 1)

_____

D. **Applicant or Agency Address**

_____

E. **Phone Number**:_____

F. **Email Address**:_____

G. Do you have a **National Provider Identifier**? (attachment 2) ◯Yes ◯No

H. Do you have a DDA **Medicaid Provider Identifier**? (attachment 3) ◯Yes ◯No

I. Do you have a **Business Tax ID**? (attachment 4) ◯Yes If Yes, #_____◯No

J. Is Your Agency? ◯**For Profit** ◯**Non Profit**

K. **Is Your Agency Incorporated**? ◯Yes ◯No
(If Yes, Please provide articles of incorporation or articles of organization for your agency)

L. Is Your Agency registered as a **Minority Owned Business**? ◯Yes ◯No

M. Is Your Agency listed as a **Disadvantaged Business Enterprise**? ◯Yes ◯No

N. Primary Contact Information

CEO/Executive Director Name: _____

1. Address: _____
2. Phone Number: _____
3. Email address: _____

CFO/Billing Contact Name: _____

4. Address: _____
5. Phone Number: _____
6. Email address: _____

Board of Directors Chairperson/President Name: _____

7. Address: _____
8. Phone Number: _____
9. Email address: _____

II. Proposed or Current Services (check the services you want to provide under DDA)

A. Certified Services

◯**Behavioral Support Services**

- Behavior Assessment to include Virtual Option*
- Behavior Plan
- Behavioral Consultation to include Virtual Option*
- Brief Support Implementation

◯**Employment Services**

- ☐ Co-worker Employment Services
- ☐ Discovery
- ☐ Self-Employment Development Supports
- ☐ Follow Along Supports*
- ☐ Job Development*
- ☐ Ongoing Job Supports*

◯**Housing Support Services**

- ☐ Virtual Option*

◯**Personal Supports**

- ☐ Virtual Option*
- ☐ Acute Care Hospital Setting Option**

◯**Career Exploration- Community**

◯**Nursing Support Services**

◯**Remote Support Services**

◯**Shared Living Services**

◯**Supported Living Services**

◯**Fiscal Management Services**

◯**Community Development Services**

- ☐ Virtual Option*
- ☐ Acute Care Hospital Setting**

◯**Targeted Case Management**
(Coordination of Community Services)

◯**Organized Healthcare Delivery Services**

- ☐ Assistive Technology and Services
- ☐ Environmental Assessment
- ☐ Environmental Modifications
- ☐ Live-in Caregiver Supports
- ☐ Transition Services
- ☐ Transportation Services
- ☐ Vehicle Modification Services
- ☐ Respite Care- 15 minutes
- ☐ Respite Care- Camp
- ☐ Respite Care- Daily (CLGH)
- ☐ Family and Peer Mentoring Supports
- ☐ Family Caregiver Training and Empowerment Services
- ☐ Participant Education, Training, and Advocacy Supports

*Denotes that Virtual Options are available for this service. Needs a Program Service Plan.

**Needs a Program Service Plan.

B. Licensed Services

◯**Adult Community Living Group Home Services**

- ☐ Community Living Group Home
- ☐ CLGH- Respite Daily
- ☐ Community Living – Group Home Trial Experience
- ☐ Acute Care Hospital Setting Option**

◯**Adult Community Living Group Home- Enhanced Supports**

- ☐ Community Living Respite – Enhanced Supports
- ☐ Community Living – Enhanced Supports Trial Experience
- ☐ Acute Care Hospital Setting Option**

◯**Children's Residential Services**

- ☐ Community Living Group Home and Respite Services

◯**Day Habilitation Services**

- ☐ Virtual Option
- ☐ Acute Care Hospital Setting Option**

◯**Career Exploration- Provider licensed site**

C. Do you have an application pending approval to provide services/supports to DDA waiver participants? ◯Yes ◯No ***If yes****, please indicate proposed licensed, OHCDS, and/or DDA-certified services*

D. Please list the licensed, Organized Health Care Delivery System and DDA-certified services you have already been authorized to provide and/or are currently providing to DDA waiver participants:

E. Please list the new services you want to add with this application that you are not already approved for:

F. Check all areas where services (current and proposed) will be provided:

◯**Central Maryland**:
□Anne Arundel Co. □Baltimore City □Baltimore Co. □Harford Co. □Howard Co.

◯**Eastern Shore Maryland**:
□Caroline Co. □Cecil Co. □Dorchester Co. □Kent Co. □Queen Anne's Co. □Somerset Co. □Talbot Co. □Worcester Co

◯**Southern Maryland**:
□Calvert Co. □Charles Co. □Montgomery Co. □Prince George's Co. □St. Mary's Co.

◯**Western Maryland**:
□Allegany Co. □Carroll Co. □Frederick Co. □Garrett Co. □Washington Co.

III. EXPERIENCE AND TRAINING

Individual Applicants must complete this section or attach a resume that includes the information below. Provider Agency applicants must submit resumes for Chief Executive Officers, Directors, Managers, and Supervisors overseeing waiver services, which demonstrate that the education and/or experience requirements are met.

A. **Applicant's Education**

Do you have a High School Diploma ◯Yes ◯No or ◯GED
Name of High School or GED Program: _____
Address: _____
Dates Attended: _____

Do you have a College Degree ◯Yes ◯No
Name of University: _____
Address: _____
Degree or Major: _____
(attachment 6)

Do you have a College Degree ◯Yes ◯No
Name of University: _____
Address: _____
Degree or Major: _____
(attachment 6)

B. Relevant Work Experiences and Skills

Please list or attach in the form of a resume, all relevant work experiences involving people with Intellectual and Developmental Disabilities, starting with your most recent experience. Applicants must have at least 5 years of relevant work experience. If more space is required, you may attach additional pages to this application. DDA will consider whether the experience was full or part-time, based on the number of years, and the nature and intensity of needs of persons served against applicable eligibility criteria.

Name of Business: _____
Address: _____
Start Date: _____End Date: _____
Supervisor's Name:_____Title: _____
Phone Number: _____Email Address: _____
◯Full Time ◯Part Time Your work responsibilities:
_____

_____

_____

Name of Business: _____
Address: _____
Start Date: _____End Date: _____
Supervisor's Name:_____Title: _____
Phone Number: _____Email Address: _____
◯Full Time ◯Part Time Your work responsibilities:
_____

_____

_____

Name of Business: _____
Address: _____
Start Date: _____End Date: _____
Supervisor's Name:_____Title: _____
Phone Number: _____Email Address: _____
◯Full Time ◯Part Time Your work responsibilities:
_____

_____

_____

C. Relevant Licenses, Certifications, and Specialized Trainings
Provide type, number, expiration date(s), and grantor. Submit this information and copies as Attachment 7. Also see specific information which should be provided in the Instructions for Completing DDA Provider and Re-Enrollment Applications for DDA Approval, DDA as a Qualified Supports/Services Provider ("QSP"), page 3.

IV. ADDITIONAL INDIVIDUAL OR AGENCY APPLICANT INFORMATION

A. Are you the sole owner of the Agency?
◯Yes ◯No ◯ Not applicable (Agency is incorporated)
If yes, provide a copy of your Social Security card. If not, please indicate your role and provide the full legal names, dates of birth, addresses, telephone numbers, email addresses, and social security numbers for each direct or indirect owner. Label information requested as Attachment 8.

B. Have you obtained three (3) professional letters of reference attesting to your ability and your manager(s) and supervisors' ability to deliver the service/support for which approval is sought?
◯Yes ◯No ◯Not applicable
If yes, please submit each professional reference as Attachment 9. Existing DDA agencies are exempt from this requirement.

C. Are you or is your Agency credentialed, accredited, or certified?
◯Yes ◯No ◯Not applicable
If yes, provide the name of the accrediting body, a copy of the license or certification, the state that issued the credential, accreditation, or certification, and the service(s) that are accredited, and submit as Attachment 10.

D. Do you or the Agency have general commercial liability insurance?
◯Yes ◯No
If yes, please specify the vendor, policy number, and coverage dates, or a price quote for the Applicants. Submit this information and copies of coverage or quotes and label as Attachment 11. If no, please explain.

E. Do you have automobile insurance for all cars that will be used to conduct business?
◯Yes ◯No
If yes, specify the vendor, policy number, and coverage dates. Submit this information and copies of coverage as Attachment 12. If no, please explain.

F. Are you or the Agency currently approved or licensed, or have you or the Agency been approved or licensed in the last five (5) years to provide services with any other state of Maryland or out-of-state agency?

◯Yes ◯No If yes, please specify approved/licensed services, population served, and submit a copy of license(s). Also submit current and prior licensing reports issued within 10 years from any in-state or out-of-state entity, including deficiency reports and compliance records, and label as Attachment 13.

Note: During the evaluation of your application, DDA may request that you provide for review Office of Health Care Quality deficiency reports regarding DDA licensed services, which were funded during the last 10 years.

G. Have you or the Agency been awarded any contracts and/or funding to provide licensed or non-licensed services/supports in the last five (5) years to any state of Maryland or out-of-state agency?

◯Yes ◯No If yes, please specify the nature, amount of services, population served, and term dates, if applicable. If you or the Agency has provided services in Maryland and another state, but no longer do so, please explain why you no longer provide those services.

H. Aside from the governing body required by COMAR 10.22.02.08, do you have any additional boards appointed to make decisions related to your Agency's operations?

◯Yes ◯No *(Individual Applicants should skip this question.)* If yes, please explain.

I. **Do all locations in which new supports/services are proposed to be provided meet the federal Community Settings Rule (CSR)?** ◯Yes ◯No ◯Not applicable

If you are a current provider with existing sites, they must meet Community Settings Rule requirements. Please attach your approval letter to this application as Attachment 19. If you checked not applicable because you do not currently have any licensed sites or proposed licensed sites, please specify how you will ensure your eventual sites will meet the federal Community Settings Rule.

J. **Provide your Agency's mission statement and describe how you will support individuals with developmental disabilities to live a life as diverse and enriching as others living in their communities.** (Existing DDA agencies can skip this question.) Add additional pages if needed. If you are applying as an individual behavior support or an individual nursing professional, please describe what should be considered when supporting participants with challenging behaviors, co-occurring illnesses, and significant health needs.

K. **Describe how you or the Agency will ensure that individuals will have input regarding the services/supports that you provide.** (Please skip this question if you are an Agency Applicant and have completed the Agency Questionnaire and Information Form.)

L. Are you or is your Agency in good standing with the IRS and/or the Maryland State Department of Assessments and Taxation?

◯Yes ◯No If no, please explain. *If the application is for renewal of DDA Approval or License to render current services and supports, attach completed IRS Form 990 for the previous year if the business is a non-profit, or a completed Form 1120 if the business is a for-profit. Label all information as Attachment 14. Information will be kept confidential and may be disclosed only in accordance with the provisions of the Maryland Public Information Act, General Provisions. Art., Title 4, MD Ann. Code.*

M. Do you or your Agency have any outstanding debts to or disallowances from DDA, or other state and/or federal agencies, such as recoupments being made to creditors?

◯Yes ◯No

If yes, please explain and include any documentation that identifies these matters, i.e., financial audits..

N. Have you, your Agency, CEO, Executive Director, owner(s), manager(s) and/or supervisor(s) ever been disciplined in a manner which has resulted in sanctions, a reprimand, suspension, and/or expulsion from providing DDA-funded services or from participating in a state, federal, or local program or contract (i.e., Medicaid and/or Medicare), or private program?

◯Yes ◯No If yes, please explain.

O. Have you, your Agency, CEO, Executive Director, owner(s), manager(s), and/or supervisor(s) ever been affiliated with any program providing health care that has been placed on the Medicaid exclusion list?

◯Yes ◯No If yes, please explain.

P. Have you, your Agency, CEO, Executive Director, owner(s), manager(s), and/or supervisor(s) ever been convicted of a criminal offense, including any program under Title 18, 19, or 20 of the Social Security Act?

◯Yes ◯No

If yes, please explain, providing detailed information about the conviction, including but not limited to: date, state, county, court, nature, and type of offense or violation, and penalty imposed.

Q. Are the required Criminal Justice Information Services (CJIS) background or criminal history checks for the Applicant or Agency CEO, Executive Director, manager(s) and/or supervisor(s), behavioral support professional(s), and owner(s) included in this application?

◯Yes ◯No

Please attach the required CJIS background or criminal history checks as Attachment 15.

R. If you propose to serve children, do you or your Agency CEO, Executive Director, manager(s), and/or supervisor(s), and owner(s) of your Agency who will have direct access to children, have child protective clearance(s)?

◯Yes ◯No ◯Not applicable

Please attach Child Protective Clearance(s), if applicable, and label Attachment 16. If no, please explain.

S. Did any person(s), paid or unpaid, assist you with the completion of this application?

◯Yes ◯No

V. DISCLAIMER

I hereby affirm under the penalties of perjury that the information given by me in this application is true and complete to the best of my knowledge and belief. I understand that to falsify information is grounds for disapproval of my application and for discharge as a provider should DDA be made aware of information contrary to what has been provided in this application. I authorize DDA to request and receive information from any person, organization, or company listed on this application regarding my previous employment, education, and qualifications to provide services and support under DDA's Community Pathways Waivers.

Privacy Notice – The information in your application is not routinely shared with other governmental agencies. However, by accepting this notice of privacy, I understand that the Maryland Department of Health's Medicaid Program, auditors, inspectors, and other government officials may review it.

Applicant's Signature: _____Applicant's Title:_____Date_____

VI. REQUIRED INFORMATION and ATTACHMENTS FOR ALL PARTICIPANTS:

A. Previous trade name and documentation for "doing business as," if applicable, labeled as Attachment 1;
B. Verification of the National Provider Identifier in the form of a document generated by the National Plan and Provider (NPPES), if applicable, labeled as Attachment 2;
C. Letter or document verifying DDA Medicaid Provider Number, if assigned, labeled as Attachment 3;
D. Letter from IRS verifying Business Tax ID number labeled as Attachment 4;
E. A copy of the Articles of Incorporation, if applicable, labeled as Attachment 5;
F. Copies of college degree(s) and resume(s) for all initial Applicants labeled as Attachment 6 (This attachment is not required for renewal Applicants);
G. Copies verifying relevant licenses, certifications, and training for all initial Applicants. Renewal Applicants should provide updated licenses, certifications, and evidence of training. Documents should be labeled as Attachment 7;
H. A copy of the initial Applicant's social security card and the owner's social security numbers and information labeled as Attachment 8;
I. Three letters of professional references, if an initial Applicant, labeled as Attachment 9;
J. Agency Credentials, Accreditations, or Certifications, if applicable, labeled as Attachment 10;
K. Copy of General Commercial Liability Insurance Coverage, or price quote for initial Applicants, labeled as Attachment 11;
L. Copy of Automobile Coverage pages labeled as Attachment 12;
M. Other State or Agency license(s) and prior licensing reports issued within the previous 10 years from any in-state or out-of-state regulatory office, including deficiency reports and compliance records (excluding OHCQ deficiency reports for DDA licensed services) labeled as Attachment 13;
N. Completed IRS Form 990 if non-profit, or Form 1120 if for-profit, for the previous year of business labeled as Attachment 14;
O. Required CJIS criminal background checks and for agencies, a current Table of Organization which identifies CEOs, Executive Directors, Managerial and Supervisory staff names, and the waiver services this staff oversees. Please label these documents as Attachment 15. Note: See page 3 of the Instructions for completing and submitting required background checks for the DDA Provider Application.
P. Child Protective Clearance(s), if applicable, labeled as Attachment 16;
Q. Conditions of Participation form; and
R. Application Checklist.

PLEASE ENSURE ALL DOCUMENTS ARE SIGNED AND DATED BEFORE SUBMISSION
🛑STOP HERE IF YOU ARE A BEHAVIORAL OR NURSING SERVICES ONLY APPLICANT

VII. AGENCY QUESTIONNAIRE AND INFORMATION FORM

This form should be completed in its entirety for initial Agency applications and Agencies seeking to renew DDA Certification and/or licensure. Current providers should indicate how information has changed since the previous application and provide current dates as applicable.

A. If applying for a license, has your Agency developed policies and procedures that meet requirements in COMAR 10.22.02.10?

◯Yes ◯No ◯Not applicable If DDA approves your application, policies and procedures must be submitted to OHCQ within 30 days of the date of approval of the application.

B. Do you have workers' compensation insurance coverage?

◯Yes ◯No Submit a copy of the document verifying your worker's insurance compensation vendor, coverage, and term dates, and label as Attachment 17.

C. Do you have unemployment insurance coverage?

◯Yes ◯No Submit a copy of the document verifying your unemployment insurance coverage vendor, coverage, and term dates, and label as Attachment 18.

D. Do you have a policy with written bylaws that includes Governing Members' qualifications, role, frequency of meetings, minutes, etc.?

◯Yes ◯No ◯Not applicable Providers must complete the Governing Body Board of Directors' form and meet requirements in COMAR 10.22.08.

E. Program Service Plan required by COMAR 10.22.02.09

All initial Agency Applicants (including those proposing to render non-licensed, DDA-certified services only) must have a Program Service Plan. The Program Service Plan must reflect current and include all waiver services for which an applicant is seeking initial or renewal approval. The Program Service Plan must specify if more than one person will receive services under the residential (group home) and/or supported living services provision. Applicants seeking to renew their licenses or DDA Certification to render services must submit Program Service Plans with signatures and dates that reflect approval and annual review from their Governing Body Members, the CEO, or an administrator (as applicable), respectively. Submit the Program Service Plan and label it as Attachment 19.

Is there a Program Service Plan included in this application?

◯Yes ◯No *Please note, the Program Service Plan (PSP) must be reviewed by the governing body and updated at least every 3 years. To make a change to an approved PSP, a revised PSP must be submitted for the Administration's approval before the implementation of the changes.*

Please check if the Program Service Plan includes the following required components:

1. **Rationale**, including a discussion of the applicant's mission, values, and philosophy for the provision of services. ◯Yes ◯No

2. **Scope**, including a discussion of how each specific service is to be provided.
◯Yes ◯No

3. **Staffing**, including a description of the staff or care providers necessary to provide each particular service as described. ◯Yes ◯No

4. **Training**, including a description of any additional training required by staff other than required per COMAR 10.22.02.11 (staffing requirements). ◯Yes ◯No

5. **Setting and location**, including a description of where the services are to be provided and the number of individuals expected to be served. ◯Yes ◯No

F. Quality Assurance Plan

All initial Agency Applicants (including those proposing to render non-licensed, DDA-certified services only) must have a Quality Assurance Plan. Applicants seeking to renew their licenses or DDA Certification to render services must submit a Quality Assurance Plan with signatures and dates that reflect approval and annual review from their Governing Body Members, the CEO, or an administrator (as applicable), respectively. Renewal Applicants must also submit their Annual Quality Assurance Plan Data Approval letter from DDA. Submit the Quality Assurance Plan and label it as Attachment 20.

1. Is there a Quality Assurance Plan included in this application?
◯Yes ◯No

Please check if the Quality Assurance Plan includes the following required components.

2. Methods for ensuring that participants' preferences and choices are honored, and there are personal contacts with participants.
◯Yes ◯No
3. Describes how the Agency will support participants with developmental disabilities to participate in integrated community activities. Licensed providers can indicate yes if a policy was previously submitted and approved by OHCQ, addressing this.
◯Yes ◯No

4. Person-centered plans for participants with measurable outcomes. ◯Yes ◯No

5. Activities involving collection and evaluation of data, analyzing trends, and appropriate interventions (which address incident reporting, evaluating and meeting behavior supports and/or health needs of participants, and use of restrictive interventions).
◯Yes ◯No

6. Goals and proactive strategies for accomplishing goals for the delivery of quality services and supports. ◯Yes ◯No

G. Methods which ensure the following:

1. All employees providing direct services to participants with developmental disabilities are required to undergo criminal background checks.◯Yes ◯No

2. Current and prospective employees convicted of crimes posing a risk to participants with developmental disabilities do not provide direct services and/or are not assigned duties that require them to work alone with individuals. ◯Yes ◯No

3. Current and prospective employees will meet statutory and regulatory requirements in the DDA policy of reportable incidents and investigations, rights of individuals afforded in Annotated Code of Maryland, Health- General, 7-1002, and required training in COMAR 10.22.02. ◯Yes ◯No

H. Describe in detail your experience operating a business. If you do not have this experience, please describe how you will obtain this expertise. Please skip this question and check "not applicable" if you are a renewal Applicant. ◯Not applicable

I. Proposed Budgets

If a DDA license and/or certification is granted to your Agency, payment for services and supports may not be received for up to 180 days from the date of service initiation. You will incur operating expenses during this period. Initial Applicants must submit the Agency's proposed budget for the first year of services and a projected budget for the next year. Agencies renewing a DDA certification or license must submit their current budget and fiscal verification forms. All Applicants must also ensure the submission of tax documents indicated in Attachment 14.

1. Are there current and/or proposed budgets included in this application as required?
   ◯Yes ◯No Submit budgets and fiscal verification forms as Attachment 21.

2. Please check if budgets include the following required components:

a. Costs incurred from specified positions and employee salaries, taxes, equipment, insurance, space, transportation/travel, training, supplies, etc. ◯Yes ◯No

b. Sources and amounts of start-up funds for initial Applicants. Information provided must include verification of income in the form of a current letter (within 30 days of submission of application) from an accredited bank or other financial institution documenting a line of credit, business loan, or availability of funds in the owner's name.
   ◯Yes ◯No ◯Not applicable (current provider)

c. All sources of income and details for any fundraising activities. ◯Yes ◯No

3. Please explain how the Agency will ensure sound fiscal operations.

4. Does the Agency have any outstanding debts to or disallowances from DDA, other state and/or federal agencies? ◯Yes ◯No If yes, please explain.

J. Organized Health Care Delivery System

Agencies designated as Organized Health Care Delivery System (OHCDS) may subcontract with Medicaid and non-Medicaid providers to allow individuals to receive services approved in their Person Centered Plan in the manner that best suits their needs and results in the more complete fulfillment of their plans.

To qualify as an Organized Health Care Delivery System, an Applicant/Provider must:

Provide at least one Medicaid service, such as:

1. Support services designated by the department
2. Day Services
3. Employment Services
4. Residential Services
5. Any other services designated by the department;
6. Be an enrolled Medicaid provider and render at least one Medicaid Service directly; and
7. Meet other requirements in COMAR 10.22.20

Are you applying to be designated as an organized health care delivery system provider?
◯Yes ◯No If yes, please complete the Organized Health Care Delivery System Application form and submit it with your application labeled as Attachment 22.

VIII. ADDITIONAL ATTACHMENTS FOR AGENCIES

A. Completed Agency Questionnaire and Information Form;
B. Copy of document verifying your worker's insurance compensation vendor, coverage, and term dates labeled as Attachment 17;
C. Copy of document verifying your unemployment insurance vendor, coverag,e and term dates, and labeled as Attachment 18;
D. DDA Program Service Plan for all service(s) applied for, or a current DDA PSP approval letter labeled as Attachment 19;
E. DDA Quality Assurance Plan/Information or current DDA QA approval letter, and transition plan approval letter for current provider existing licensed sites, if applicable, and label each document as Attachment 20;
F. Budgets and fiscal verification forms labeled as Attachment 21;
G. Organized Health Care Delivery System Application form, if applicable, labeled as Attachment 22.

PLEASE ENSURE ALL DOCUMENTS ARE SIGNED AND DATED BEFORE SUBMISSION

IX. LICENSED PROVIDER APPLICANT AND RENEWAL PROVIDERS – ADDITIONAL FORMS REQUIRED AND REVIEWED BY OHCQ

A. Governing Body – Board of Directors Form;
B. Staff Training Form – COMAR 10.22.02;
C. Staff Training Form – Office of Children, if applicable;
D. Staff Criminal History Form;
E. Policies and Procedures Form;
F. List of Licensed Site Locations Form (if applicable; renewals only); and
G. Addendum Application for Current License Form (to add a new site), if applicable.

X. DISCLAIMER FOR AGENCY APPLICANTS

Applicant/Renewal Provider's signature attests that all information in the Agency Questionnaire and Information Form are accurate and the required attachments are included with this application.

Printed Name and Title:_____Date: _____

Signature: _____

XI. POLICIES REQUIRED FOR CHILDREN'S RESIDENTIAL SERVICES (COMAR 14.31.06)

A. Copies of the Program Administrator's required degrees, licenses, resume, and letter of appointment by the Board (COMAR 14.31.06.06(A)(2))
B. Description of facility, including diagram (COMAR 14.31.06.07)
C. Menu plan and Nutritional Consultant's report (COMAR 14.31.06.10.B.(2) & (9) (b))
D. Letters of support/documentation of need
E. Program service plan addresses:

1. Philosophy of provision of services
2. Capacity of facility
3. Sex and age range of participants
4. Admission criteria
5. Client rights and grievance procedures
6. Individual service plans
7. Treatment Modalities
8. Family Involvement
9. Daily routines
10. Life needs
11. Religious activities
12. Allowances/money
13. Clothing/personal belongings
14. Personal hygiene standards
15. Sleep
16. Life skills
17. Training
18. Somatic health care
19. Child abuse and neglect
20. Discipline
21. Absent without leave (AWOL)
22. Discharge

F. Written policies and procedures as per COMAR, reference noted in parentheses:

1. Organization and administration (14.31.05.04)
2. Governance (14.31.06.04)
3. Personnel administration (14.31.06.05)
4. Employee duties and qualifications (14.31.06.06)
5. Emergency and General Safety, (14.31.06.08)
6. General program requirements (14.31.06.09)
7. Basic life needs (14.31.06.10)
8. Children's rights (14.31.06.11)
9. Children's services (14.31.06.12); (14.31.06.13)
10. Child abuse and neglect (14.31.06.14)
11. Behavioral Interventions, Strategies, and Supports (14.31.06.15)
12. Absence without leave (14.31.06.16)
13. Admission, individual service plan, behavior plan, and discharge (14.31.06.17)
14. Reports and records (14.31.06.18) and
15. Additional as required for licensure of specialized programs (14.31.07)

G. Physical plant inspection, including:

1. Report of Public Health Authority COMAR 14.31.06.07(A)(4)(a)
2. Report of Public Fire Authority COMAR 14.31.06.07(A)(4)(a)