MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION PT 54 - IMD Residential SUD Adult

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **9 am – 5 pm.**

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov), for enrollment, information updates, provider affiliations, and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

After you receive your Medical Assistance enrollment approval, your Carelon ID number will be emailed, faxed, or mailed to your address of record.

Once you receive your ID, please register with Carelon Behavioral Health of Maryland for authorization.

Visit https://maryland.carelonbh.com for more information.

If you need assistance obtaining your Carelon ID, please contact Carelon at 1-800-888-1965 (Press 1 for English, then 3 for Provider, then 7 for EDI) or email provider.relations.md@carelon.com

Please visit https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx for more information about ePREP.

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Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

CHECKLIST		
Please utilize this checklist to confirm you have submitted all the required documents uploaded to your application in ePrep.		
☐	To enroll as an IMD Residential SUD Adult provider, you **must** have a license issued by the Behavioral Health Administration that includes at least one of the following levels of care: Check if you have an active Behavioral Health Administration (BHA) license for one or more of the following levels of care: ● Level 3.1 ● Level 3.3 ● Level 3.5 ● Level 3.7 ● Level 3.7 WM	If not, you may contact BHA at bha.regulations@maryland.gov for more information about the licensing process.
☐	Check if you have entered the applicable BHA license number (s) in ePREP and uploaded a copy of the active license.	Please enter each license number for each specific service applicable to the application.
☐	Check if you have uploaded the license and credentials of **all** professionals employed by or under contract with the provider.	Required by COMAR 10.09.06.04
☐	Check if you have uploaded pre-employment criminal history records for each employee.	Required by COMAR 10.63.01.05

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☐	Check if you have uploaded a written policy regarding the criminal history of the program's employees, contractors, and volunteers. **At a minimum, it includes consideration of the following:** (a) The age at which the individual committed the crime; (b) The circumstances surrounding the crime; (c) Any punishment imposed for the crime, including any subsequent court actions regarding that punishment; (d) The length of time that has passed since the crime; (e) Subsequent work history; (f) Employment and character references; and (g) Other evidence that demonstrates whether the employee, contractor, or volunteer poses a threat to the health or safety of a program participant, program staff, or a member of the public. **Please note:** (4) An individual may not be hired as an employee, contractor, or volunteer: (a) For a program serving participants younger than 18 years old, if the individual has been convicted at any time of child abuse or child sexual abuse; or (b) For a program serving participants 18 years old or older, if the individual has been convicted at any time of abuse or neglect of a vulnerable adult.	Required by COMAR 10.63.01.05
☐	Check if you have completed the Adult Residential SUD Provider Attestation Form (pages 4-9).	

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Adult Residential SUD Provider Attestation Form

ASAM Levels 3.3 to 3.7-WM (3.1 effective 1/1/2019)

Program/Facility Name: _____

Facility Address: _____

City/State/Zip: _____

NPI Number: _____

License Number: _____

Maryland Department of Health ("the Department") program requirements follow the criteria defined by the American Society of Addiction Medicine (ASAM) for the provision of substance use disorder treatment services. Providers shall have a current version of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed.*, and provide services that meet these criteria.

If your organization meets a specific level of care based on the ASAM Criteria, and have trained and knowledgeable staff in applying the ASAM Criteria, you must complete this Provider Attestation Form and any additional required credentialing and/or contracting documents.

The Department will inform you if you meet the requirements to be enrolled or credentialed as a Medicaid provider. Attesting to meeting ASAM Criteria does not guarantee enrollment as a Medicaid provider.

Program Requirements

By signing this attestation, you certify that the program has an active Behavioral Health Administration-issued license and complies with all relevant Department regulations, including but not limited to COMAR 10.09.36 and COMAR 10.63.

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Program Types

By marking "Yes," you attest that the following ASAM Levels of Care (LOC) are offered at your facility, that you have received licensure from the Office of Health Care Quality for each LOC, and that you

Program Type	ASAM LOC	Provide Service	
		Yes	No
Clinically Managed Low-Intensity Residential Services Clinically Managed Low-Intensity Residential Services provides 24-hour living support and structure with available trained personnel and offers at least 5 hours of therapeutic services a week.	**3.1**	☐	☐
Residential Medium Intensity Program Clinically-managed substance-related disorder treatment based on a comprehensive assessment. Provides services in a structured environment in combination with medium-intensity treatment and ancillary services to support and promote recovery.	**3.3**	☐	☐
Residential High Intensity Program Clinically-managed substance-related disorder treatment based on a comprehensive assessment. Provides services in a highly-structured environment, in combination with moderate- to high-intensity treatment and ancillary services to support and promote recovery;	**3.5**	☐	☐
Residential Intensive Program Provide medically-monitored, intensive substance-related disorder treatment based on a comprehensive assessment. Offers a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting;	**3.7**	☐	☐
Withdrawal Management Service Offers 24-hour medically supervised evaluation and withdrawal management.	**3.7-WM**	☐	☐

are compliant with all applicable Department regulations for the LOC indicated.

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Required Evidence Based Practices

As part of the approval from CMS for the IMD waiver for adults, the State agreed to require demonstrated competency in and deliver a minimum of three evidence-based practices (EBPs). For further information, please see the provider manual. By marking "Yes" you attest that the following EBPs are offered by the program:

Evidence-Based Practice Services	Services Provided	
	YES	NO
Acceptance and Commitment Therapy (ACT)	☐	☐
Cognitive Behavioral Therapy (CBT)	☐	☐
Medication Assisted Treatment (MAT)	☐	☐
Motivational Enhancement Therapy (MET)	☐	☐
Motivational Interviewing (MI)	☐	☐
Psychoeducation	☐	☐
Psychotherapy	☐	☐
Relapse Prevention (RP)	☐	☐
Solution-Focused Group Therapy (SFGT)	☐	☐
Supportive Expressive Psychotherapy (SE)	☐	☐
Trauma Informed Treatment	☐	☐

The program will demonstrate competence in the aforementioned EPBs through:

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Staffing

By marking "Yes" you attest that the program employs, at minimum, the following staff:

ASAM Level 3.1 (effective 1/1/2019)	**Employed Staff**	
	Yes	No
Program Director on-site 20 hours/week	☐	☐
Clinical Director on-site 20 hours/ week (may also serve as the Program Director)	☐	☐
Licensed or certified counselor on-site 40 hours/ week	☐	☐
Peer Support Staff (Recovery Coach)	☐	☐
Aftercare Coordinator	☐	☐

ASAM Level 3.3	**Employed Staff**	
	Yes	No
Physician, NP and/or PA (on-site 4 hours/week, 1 hour on call)	☐	☐
Psychiatrist or Psychiatric NP (available 3 hours per week)	☐	☐
Nurse RN or LPN (on-site 40 hours per week)	☐	☐
Facility Director (on-site 20 hours per week)	☐	☐
Clinical Supervisor	☐	☐
Certified Counselors (Clinical SUD)	☐	☐
Licensed Mental Health Clinician	☐	☐
Peer Support Staff (Recovery Coach)	☐	☐
Aftercare Coordinator	☐	☐

ASAM Level 3.5	**Employed Staff**	
	Yes	No
Physician, NP and/or PA (on-site 1 hour a week)	☐	☐
Psychiatrist or Psychiatric NP (available 1 hour a week)	☐	☐
Facility Director (on-site 20 hours per week)	☐	☐
Clinical Supervisor	☐	☐
Certified Counselors (Clinical SUD)	☐	☐
Licensed Mental Health Clinician	☐	☐
Peer Support Staff (Recovery Coach)	☐	☐
Aftercare Coordinator	☐	☐

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ASAM Level 3.7	**Employed Staff**	
	Yes	No
Physician, NP and/or PA (on-site 5 hours per week, 2 hours on call)	☐	☐
Psychiatrist or Psychiatric NP (available 10 hours per week)	☐	☐
Nurse RN (on-site 56 hours per week)	☐	☐
Nurse LPN (on-site 112 hours per week)	☐	☐
Facility Director (on-site 20 hours per week)	☐	☐
Clinical Supervisor	☐	☐
Certified Counselors (Clinical SUD)	☐	☐
Licensed Mental Health Clinician	☐	☐
Peer Support Staff (Recovery Coach)	☐	☐
Aftercare Coordinator	☐	☐

ASAM Level 3.7-WM	**Employed Staff**	
	Yes	No
Physician, NP and/or PA (on-site 20 hours per week, 4 hours on call)	☐	☐
Psychiatrist or Psychiatric NP (available 8 hours per week)	☐	☐
Nurse RN (on-site 56 hours per week)	☐	☐
Nurse LPN (on-site 112 hours per week)	☐	☐
Facility Director (20 hours per week)	☐	☐
Clinical Supervisor	☐	☐
Certified Counselors (Clinical SUD)	☐	☐
Licensed Mental Health Clinician	☐	☐
Peer Support Staff (Recovery Coach)	☐	☐
Aftercare Coordinator	☐	☐

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I hereby certify that all information contained in this document is true and accurate. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreement that I have or may enter into with MDH and/or its contractors.

In compliance with the MDH Provider Attestation Form, the Facility attests that it will permit only staff members who are fully licensed and/or meet MDH program requirements to see and treat Medicaid eligible members.

I hereby give permission and consent for MDH and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to MDH and/or its contractors, of all information relevant to the evaluation of my ability to render addiction recovery and treatment services in a cost-effective manner and my moral and ethical qualifications, and agree to hold harmless any such person or organization from any cause of action based on the release of such information to MDH and/or its contractors.

By signing this attestation I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement.

Printed Name: _____

Title: _____

Signature:_____ **Date:**_____

If you have any questions please contact program staff
at: mdh.bhenrollment@maryland.gov