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| SSeal_647C | HEALTH SYSTEMS DIVISION Licensing and Certification |  |
| Tina Kotek, Governor |

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| 500 Summer Street NE, E-86  Salem, OR 97301-1118  "Voice" 503-945-5763 "TTY" 800-375-2863  "Fax" 503-378-8467  www.oregon.gov/dhs/mentalhealth |

**INITIAL ASAM LEVEL OF CARE APPLICATION**

**– MAIN FORM –**

**OUTPATIENT, RESIDENTIAL & WITHDRAWAL MANAGEMENT**

**Date of submission:**

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| **SECTION I: INSTRUCTIONS** |
| * Please complete this application in full, incomplete applications may require resubmission. * Attestation of Compliance: legibly write in the program name at the top, sign, and date. * Documents shall be submitted **via email** and according to the following instructions:   + Name documents as closely as possible to reflect the rule language   + Zip files; HSD security rejects emails containing more than 25 MB   + Submit templates or documents from the file of a test account. No PHI.   + **Complete applications shall be submitted by *non-encrypted* email**to [sud.waiver@odhsoha.oregon.gov](mailto:sud.waiver@odhsoha.oregon.gov) and include the Compliance Specialist (CS) for your region for outpatient services   + Use the subject line: “OP ASAM LOC APP for \_” (insert name of program).      * For questions, assistance, or accommodation to submit in a manner other than email, please contact Melissa Farin at [melissa.c.farin@oha.oregon.gov](mailto:melissa.c.farin@oha.oregon.gov) |
| **NOTICE:**  **All providers certified to render substance use disorder treatment services must select at least one outpatient ASAM Level of Care and apply for approval to render services in accordance with those rules.** |
| |  | | --- | | **NOTICE:**  **Beginning April 1, 2024, rendering services for ASAM Level(s) of Care without prior approval from HSD may adversely affect continued certification of programs.** | |
| **ASAM LEVEL OF CARE APPLICATION: PREPARATION, SUBMISSION, AND HSD REVIEW FOR APPROVAL** |
| 1. Providers shall submit the ASAM Level of Care applications by October 1, 2023, and in accordance with all applicable OARs in 309-019. <https://secure.sos.state.or.us/oard/displayChapterRules.action> |
| 1. In response to the application, Health Systems Division (HSD) will complete a desk review of all submitted materials and may respond with questions, to request additional information, or request a resubmission of application materials, if incomplete. |
| 1. When additional information is required to approve the application, the applicant must provide the requested information to HSD within 14 days of receipt of the request for additional information. |
| 1. HSD shall review all applications submitted by October 1, 2023, and respond with approval, request for additional documentation or partial resubmission, or a denial – per level of care. |
| 1. Upon approval of this application, a letter of approval and an updated certificate will be issued to the agency that will contain the approved ASAM Level(s) of Care and the same renewal and expiration dates as the certificate currently on file. |
| 1. HSD shall issue updated certificates containing each approved ASAM Level of Care between January 1, 2024, and March 31, 2024. |
| 1. ASAM Levels of Care will be reviewed for approval prior to the end of the first year of approval and then with each certification renewal. When applicable, this will be done within a renewal process. |
| Please be advised that state approval does not guarantee eligibility to participate as an OHP provider. To become an OHP (Medicaid) provider, please contact **HSD Provider Enrollment Unit** by phone 800-336-6016, email: [provider.enrollment@state.or.us](mailto:provider.enrollment@state.or.us) , or by visiting the provider enrollment webpage: <http://www.oregon.gov/oha/healthplan/Pages/providerenroll.aspx> |

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| **SECTION II: APPLICANT INFORMATION** |
| 1. Name of agency: |
| 1. DBA, if applicable: |
| 1. Name *and title* of responsible party: |
| 1. Email & phone number of responsible party: |
| 1. Name *and title* and of authorized person preparing this application: |
| 1. Email & phone number of authorized person preparing this application: |
| 1. Agency Federal Entity Tax Identification number: |
| 1. Agency National Provider Identification (NPI) number: |
| 1. Agency MMIS (Medicaid) number: |
| 1. Agency Business license registration number: |
| 1. Is the agency registered as a nonprofit? Yes  No |
| 1. Does the agency accept SAPT funding or grants? Yes  No |
| 1. Complete mailing address of the agency: |
| 1. Is the agency contracted with a Coordinated Care Organization (CCO): Yes  No |
| 1. List action taken on any certificate or license of Owners and Program Directors, and anyone listed in question “P.” *since the last application submitted*. Action includes denial, suspension, conditions, intent to revoke or revocation by the Division, Oregon Health Authority, Oregon Department of Human Services, or any other state agency. Use a separate sheet if necessary.  |  |  |  |  | | --- | --- | --- | --- | | **Name of Owner/ Director** | **Certification or License BOARD** | **Issued/ Expired**  **Dates** | **Action Taken** | |  |  |  |  | |
| 1. Complete physical address where services are delivered:  |  | | --- | | **Street address with city and zip code** | |  | |  | |  | |  | |
| 1. For the list below, add each personnel responsible for managing delivery of behavioral health services ***per ASAM Level of Care***. Include: Program Director or Administrator, Medical Director, LMPs and Clinical Supervisor(s).   For each personnel listed, submit their resume/CV, contract (when applicable), and all credentials applicable to their position.   |  |  |  |  | | --- | --- | --- | --- | | **Name, Credentials** | **Title** | **Email** | **ASAM LOC** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

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| **SECTION III: IDENTIFY ASAM LEVELS OF CARE** |
| INSTRUCTIONS:   * Select each broad ASAM Level(s) of Care your business intends to render from the list below. * Each selection must correspond with an existing certificate or license or be submitted with a new application for certification or licensure. * Fill out and submit the corresponding “ASAM LOC Addendum” application(s).   CLARIFICATION:  -All ASAM Levels of Care are optional, although at least one must be selected for approval to render SUD services. |
| OUTPATIENT |
| RESIDENTIAL |
| WITHDRAWAL MANAGEMENT |

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| **SECTION IV: SUBMISSION REQUIREMENTS** | |
| State Application Form (this completed document) | |
| Personnel qualifications and credentialing policy and procedure | |
| Referral, Care Coordination and Transfer of Services policy and procedure | |
| Urinalysis Testing policy and procedure | |
| Code of conduct that includes professional boundaries and ethics | |
| Template used to document the completion of the new employee orientation trainings, the ASAM Criteria P&P training and *The ASAM Criteria* assessment training as required by OAR 309-018-0130 and/ or 309-019-0130 (as applicable to the LOC applied to render) | |
| **NOTICE**  At the next renewal review following April 1, 2024, submit evidence that all current SUD program and supervisory staff have completed the orientation training on the final version of the ASAM Criteria policy and procedure for each ASAM Level of Care and The ASAM Criteria training offered by OHA. | |
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| **SECTION V- QUESTIONAIRE**  **Submit responses to these questions in a separate document** |
| 1. How long has the program offered each ASAM Level of Care that the program has applied to render? |
| 1. Briefly describe the agency’s continuum of care, including ASAM levels of care, case management, outreach, and population specific programming such as mental health, youth, women, drug court, DUII, medication assisted treatment, etc. |
| 1. Discuss options to access and collaborate with local continuum of services. |

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| **SECTION VI: ATTESTATION OF COMPLIANCE** | | |
| Pursuant to requirements in the Oregon Administrative Rules and as the legal authority of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert name of agency),** by my signature below I attest to: | | |
| 1. I am an authorized person representing the agency intentions and best interest of all board members, shareholders and/or owners; | | |
| 1. The information provided on the application is valid and complete; | | |
| 1. The agency will comply with the Oregon Administrative Rules that govern these services; | | |
| 1. If applicable, the agency is compliant with all other licensing or accreditation entities that apply, i.e., Department of Human Services, Drug Enforcement Administration (DEA), etc.; | | |
| 1. The agency will maintain continuous liability insurance; | | |
| 1. The agency is compliant with federal, state, and local regulations that govern individual privacy and confidentiality, including, but not limited to, HIPAA, and 42 CFR Part 2; | | |
| 1. The agency will prioritize the assurance of individuals’ health, safety, and welfare. | | |
| 1. The agency will fulfill all mandatory reporting duties; | | |
| 1. The agency is not employing personnel who have been convicted of any felony, or a misdemeanor associated with the provision of behavioral health services; | | |
| 1. Agency staff will adhere to the agency code of conduct. In addition, agency staff will report suspected ethical violations (including impairment) to the responsible party and appropriate credentialing parties (such as certification boards, licensing entities, etc.); | | |
| 1. The agency will notify HSD 15 days prior to a change of the Medical Director or Executive Director by submission of qualifications requested within the Request for New Director form; | | |
| 1. The agency will notify HSD, in writing, of office location change or addition. I understand that the agency may not deliver any state approved service until the office is approved by HSD. | | |
| 1. Within two weeks of receiving state approval for outpatient mental health or substance use disorders treatment services, the agency will register with and immediately begin reporting the entry of all individuals in the mandated state data system (“MOTS”). | | |
| 1. If applicable, grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . .requirements.”); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law. | | |
| 1. I understand that Certificates of Approval are not transferable to any other person, entity, provider, or non-Division approved service delivery location. | | |
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| Authorized Signature |  | Date |
| Printed Name and Title |  |  |