DELAWARE HEALTH AND SOCIAL SERVICES
Divison of Substance Abuse and Mental Health
Always the right time, Always the right place, Always the right service

APPLICATION FOR LICENSURE and/or CERTIFICATION

Instructions for completing the application:

1. Please thoroughly review the relevant DSAMH Standards and Provider Certification Manual Standards prior to submitting this application. Unless otherwise waived, programs shall comply with these standards.

2. A separate application must be submitted for each program at each location. Applications must be submitted to the Division of Substance Abuse and Mental Health (DSAMH) at DHSS_DSAMH_ProviderEnrollment@Delaware.Gov.

3. It is important that **ALL** information on this application is complete, accurate and up to date including the licensure application fee.

4. All requested documents are to be submitted along with the completed application. **The Division shall not consider any application until all documents have been submitted and payment has been received.**

5. The Managed Care Organization and Fee For Service provider screening and enrollment application must be submitted via the Delaware Medicaid Assistance Program Provider Portal at Delaware Medical Assistance Portal for Providers > Home. A provider may not provide SUD treatment to Medicaid beneficiaries without a DSAMH approval letter and approval from the DMAP.

5. Any questions or concerns can be sent to DHSS_DSAMH_ProviderEnrollment@Delaware.gov.

PROVIDER APPLICATION CHECKLIST

Program Name: _____ Date of Application: _____

Please initial next to the applicable boxes below and include this form with the application to ensure that the necessary items are included for proper processing.

If the necessary information is not included, Provider Enrollment staff will return this form indicating what is missing and a timeframe to return the missing item(s). If the information is not received within that time, the application will be rejected and a new application will need to be submitted for processing.

Initial Application Checklist

Completed (initial or put N/A)	Documents	PE Comments
With an INITIAL application, please include:		
	Program services to be provided	
	Manual of policies and procedures in administrative, financial, personnel and program services management	
	Sample clinical chart including samples of any forms used by the program and the instructions for each form	
	Corporate and/or Advisory Board By-laws	
	Facility zoning permit	
	Copy of program floor plans	
	Documentation of facility occupancy permit (such as Certificate of Occupancy, Certificate of Use, etc.)	
	The current organizational chart	
	Staff and Board Meeting Minutes for the last six months	
	Copy of NPI registration/NPI Assignment Letter	
	Documentation of current insurance coverage	
	Copies of any current licenses, certifications and/or accreditations including business licenses as applicable	
	Most recent annual financial audit report, including sources of funding	
	Attachment A: Personnel	
	Attachment B: Governing Body	
	Attachment C: Deemed Status Application, if applicable	
	Attachment D: Application for New Opioid Programs, if applicable	

Renewal Application Checklist

Completed (initial or put N/A)	Documents	PE Comments
With a RENEWAL application, please include:		
	Any changes in the program services to be provided	
	Any new, revised, or updated policies and procedures	
	Any changes in the Electronic Health Record (EHR) being used	
	Sample of clinical chart if any changes, revisions, or updates have been made to the chart or any of the forms; include the instructions for each changed form	
	Any changes to the Corporate and/or Advisory Board By-laws	
	The current organizational chart	
	Staff and Board Meeting Minutes for the last six months	
	Documentation of current insurance coverage	
	Copies of any current licenses, certifications and/or accreditations	
	Most recent annual financial audit report, including sources of funding	
	Attachment A: Personnel	
	Attachment B: Governing Body if any changes since submission of last application	
	Attachment C: Deemed Status Application, if applicable	

I hereby confirm that the program for which I am applying for licensure and/or certification conforms to the program standards. I attest that I have reviewed this application and all supporting documents and further attest that, to my knowledge, the information is accurate and truthful. I also attest that I understand misrepresentation, inaccurate, or false information may lead to our license and/or certification being rescinded. My signature below represents this form, in its entirety, has been reviewed and completed in good faith and with due diligence.

_____ _____

President of Governing Body/Advisory Council Signature Date

_____ _____

Program Director Signature Date

_____ _____

President of Governing Body/Advisory Council Signature Date

_____ _____

Program Director Signature Date

Program Name: _____ Date of Application: _____

Check One: ☐ Initial Application ☐ Renewal Application

Check One: ☐ License and Certification ☐ Certification

Please note: a separate application is required for each program and each location.

A non-refundable application fee of $15 per application shall be submitted with each licensure application. No license application will be accepted without the application fee. Certification only applications do not require an application fee to DSAMH. Please include the specific program name and location on the check. Please send the check to:

Office of the Secretary - Administration
Financial Management Supporting DSAMH.
Delaware Department of Health and Social Services
Herman M. Holloway Sr. Health and Social Services Campus
1901 N. DuPont Highway, New Castle, DE 19720

Please send the completed application form and all supporting documentation to:
DHSS_DSAMH_ProviderEnrollment@Delaware.gov

I. ORGANIZATION INFORMATION

Name of Organization or Parent Company

Street Address

City, State, Zip

Telephone Number Fax Number

Chief Administrator Email Address

Contact Person Email Address

Organization Website

NPI Number for this program: _____
(please include a copy of the NPI registration)

FEIN Number _____

PROGRAM STATUS FOR WHICH APPLICATION IS BEING MADE:
Check all that apply.

- ☐ Non-Profit
- ☐ Non-Profit 501(C)(3)
- ☐ Public
- ☐ For Profit
- ☐ Private
- ☐ Other (Specify)

III. LICENSED PROGRAM INFORMATION

Please note: a separate application is required for each program and each location.

☐ CHECK HERE IF THE PROGRAM INFORMATION IS THE EXACT SAME AS ORGANIZATION INFORMATION. MOVE ON TO SECTION III IF CHECKED.

Program Name as It Will Appear on the License

Program Address

City, State, Zip

Telephone Number | Fax Number

Program Director | Email Address

Contact Person | Email Address

III. TYPE OF PROGRAM LICENSURE FOR WHICH APPLICATION IS BEING MADE:

Licensure and Certification Programs

Select only one. A separate application is required for each program and each location.

☐ **Outpatient Treatment Services:** Outpatient Services ASAM Level 1
☐ **Outpatient Treatment Services:** Intensive Outpatient Treatment ASAM Level 2.1
☐ **Outpatient Treatment Services:** Outpatient Services ASAM Level 1 and Intensive Outpatient Treatment ASAM Level 2.1

☐ **Opioid Treatment Services:** Opioid Treatment Program (OTP) ASAM Level 1
☐ **OTP with mobile unit --** include VIN# of mobile unit(s): _____
☐ **OTP with medication unit --** include address of medication unit: _____

☐ **Co-Occurring Outpatient Services:** Partial Hospitalization Program (PHP): Co-Occurring Treatment Services ASAM Level 2.5

☐ **Ambulatory Detoxification Services:** WM Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2
☐ **Ambulatory Detoxification Services:** WM-23 Hour Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2
☐ **Residential Detoxification Services**: WM Clinically Managed Residential Withdrawal Management ASAM Level 3.2
☐ **Residential Detoxification Services:** WM Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7

☐ **Transitional Residential Treatment:** Clinically Managed Low-Intensity Residential Treatment ASAM Level 3.1
☐ **Residential Treatment:** Clinically Managed Population-Specific High Intensity Residential Treatment ASAM Level 3.3
☐ **Residential Treatment:** Clinically Managed High Intensity Residential Treatment ASAM Level 3.5
☐ **Residential Treatment:** Medically Monitored Intensive Inpatient Treatment ASAM Level 3.7

☐ **Other (please specify):** _____

Certification Only Programs

PROMISE Programs:

☐ **ACT**

☐ **ICM**

☐ **CRISP**

☐ **Personal Care Service**

☐ **Peer Service**

☐ **Group Home**

☐ **Facility Based Crisis Intervention**

☐ **Mobile Crisis Intervention**

☐ **Other (please specify):** _____

TYPE OF CLIENT HEALTH RECORDS

Check all that apply:

☐ Electronic Health Records ☐ Hard Copy Health Records ☐ Both

IV. The Program will be accepting the following Insurances: (Check all that apply)

☐ Medicaid (AmeriHealth) ☐ Medicaid (High Mark Blue Cross Blue Shield)
☐ Tri-Care Military Insurance ☐ Private Insurances

Specify:_____
_____

V. Name and title of the individual (director/administrator etc.) who is responsible for the management of the facility:

_____ _____
Name Start Date

_____
Title

VI. AFFILIATION WITH OTHER REGULATORY OR ACCREDITATION BODIES

List all licensing, certification and/or accreditation bodies with which your organization is affiliated, including those in other states. Attach additional sheets as necessary.

☐ None

☐ LICENSURE _____
Licensing Body Expiration Date

☐ CERTIFICATION _____
Certification Body Expiration Date

☐ ACCREDITATION _____
Accreditation Body Expiration Date

☐ OTHER (specify) _____

Has the organization ever had a license, certification or accreditation denied, suspended, and/or revoked for any program it operates?

☐ No

☐ Yes - Attach a separate sheet providing the name of the program, the date, and the reason(s) for denial, suspension, and/or revocation.

☐ The program is applying for Deemed Status under:

☐ CARF ☐ TJC ☐ COA ☐ NABH ☐ ACHC ☐ ACA ☐ Other_____
Specify

Complete Attachment C: Application for Deemed Status.

VI. GEOGRAPHIC AREA(S) SERVED BY THE PROGRAM

(Please identify the Geographic area by State, County, City, Municipality, etc., as appropriate)

_____ _____
State(s) County (ies)

_____ _____
City (ies) Other

FOR INITIAL APPLICANTS: Explain the process you used (e.g., Needs Assessment) to substantiate a need for this type of program, at this time, in this geographic area. Attach any documentation that substantiates your explanation**.** **RENEWAL APPLICANTS:** Move onto section VII.

_____
_____
_____
_____
_____
_____

VII. HOURS OF OPERATION

Whenever hours of operation change, the program must notify Quality Assurance, in writing, of those changes.

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

VIII. FUNDING SOURCES

Please note that licensure does NOT constitute a contract or entitle a program to funding from the Division of Substance Abuse and Mental Health.

Dollar Amount (in thousands)	Source Description

IX. POPULATION

PLEASE PROVIDE CLIENT DEMOGRAPHIC INFORMATION

Children and Youth (17 and under) ☐ Adults (18 and over) ☐

Male☐ Female ☐ LGBTQIA+☐

List the average number of clients involved (actual/projected) in the program per month by primary diagnosis.

	Actual	Projected
Primary Alcohol or Drug	_____	_____
Polysubstance Abuse	_____	_____
Co-occurring (AOD/MH)	_____	_____
Delaware Driving Under the Influence (DUI)	_____	_____

1. Indicate the average length of stay for clients in the program (actual or projected.) Give answers in days if less than one (1) month, otherwise give answer in months.

   Actual _____ Projected _____

2. Indicate the actual/projected staff to client ratio: _____

   Complete Attachment A: Personnel

3. Indicate the actual number of members of the organizations Governing Body: _____

   Complete Attachment B: Governing Body

4. If you have or are projecting a waiting list, please indicate the number of individuals and the average waiting period preceding admission:

    1. Number of clients on waiting list:

        Actual_____ Projected _____

    2. Average waiting period preceding admission:

        Actual _____ Projected _____

Attachment A: Personnel

Program Name: _____ Date of Application: _____

List administrative and clinical staff that will provide services to consumers enrolled in the program for which you are seeking licensure.
Add additional sheets as necessary.

Name	Position/Title	Degrees and/or Credentials	Major Field of Study	Years of Experience in AOD Field	FT, PT, Consultant, or PRN

Attachment B: Governing Body

Program Name: _____ Date of Application: _____

☐ Governing Board ☐ Advisory Council

List all members of the governing authority (i.e. owner, stockholders, board of directors, advisory board) who have legal and ethical responsibility for the program. Provide all requested information.
Add additional sheets as necessary.

Indicate any relationship between a Board Member and a Staff member. Also, indicate Consumer with "C" after name and Family Member with "F" after name.

Name of Governing Member	Position or Office Held	Address

1. Please list all Governing Body members who are related to staff members of the program and explain the relationship.

2. Please explain how the Governing Body is representative of the community it serves.

3. Please list any officers/directors, partners or managing members, or member of a governing body who have a financial interest of five (5) percent or more in a licensee's operation or related business.

Attachment C: Deemed Status Application

Program Name: _____ Date of Application: _____

The program is applying for Deemed Status under:

☐CARF ☐TJC ☐COA ☐ACHC ☐ NABH ☐ Other (Specify)
_____

Date of your last accreditation survey: _____

Accreditation Status (e.g. Full Accreditation, Three Year Accreditation etc…) _____

Approximate date of your next accreditation survey: _____ _____
Month Year

If more than one program is accredited under this certificate, please provide the program names, addresses, administrator names, phone numbers and email addresses on a separate sheet.

If your program is the first program requesting Deemed Status under your organization's accreditation, please submit the following documents with your Deemed Status Application:

- A copy of your most current accreditation certificate
- A copy of your most recent accreditation survey report
- A copy of your response for corrective action based on your most recent accreditation survey report

Have these documents been submitted by another program within your organization prior to this application?

☐No ☐Yes If "Yes" please provide information on the name of the program and date of the initial submission.

_____

If more than one program is accredited under the same certificate, are all documents being submitted valid for each program?

☐Yes ☐No If "No", please list other documents for your specific program with copies of each. Include these under a separate attachment.

Please submit all documents at least ninety (90) days prior to the expiration of your current license to:

DSAMH Quality Assurance, Provider Enrollment Unit
1901 N DuPont Highway
Springer Building
New Castle, DE 19720
Email: DHSS_DSAMH_ProviderEnrollment@Delaware.Gov

Attachment D: Application for New Opioid Programs

Program Name: _____ Date of Application: _____

1. Please attach a list of all Opioid Treatment programs within your organization including: The name of the preferred contact at each program, address, phone number, fax number and email address. Please provide this information under separate attachment.

2. Please provide the name and documentation of all credentials (e.g. licenses) for all medical staff that will be working with opioid patients at the program for which you are seeking licensure:

    a. Medical Staff

        i. _____
        Medical Director License Expiration Date

    b. Other Prescribing, Professional Medical Staff:

Name	License/ Expiration Date

    c. Nursing Staff:

Name	License/Expiration Date

3. Medication Dispensing Hours

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

4. Please attach copies of the organization's protocols and procedures for Take Home and Detoxification.

5. Please attach copies of the organization's protocols for assuring adequate procedures to identify theft or diversion of Opioid antagonist medication.

6. Please attach the substantiated need for your program as required in Section V of the *Application for Licensure "For Initial Applicants."*

7. Please explain how you will collect fees from OTP consumers and the process by which you will provide continuity of care for consumers who are unable to pay for services. Include the projected number of individuals you will refer to DSAMH funded programs within the first year of providing services and documentation of how your projections were estimated.

8. Referral to Community Programs

    a. Please attach letters of agreement from community programs that you intend to refer consumers to. Include referral sources for Mental Health treatment, DUI treatment, DSAMH funded OTP programs and any other referral source you anticipate developing a relationship with.

9. Safety and Security

    a. Please explain the program's plans for assuring adequate on and off-site security measures to ensure the safety of patients, staff and business and residential neighbors.

Please include ATTACHMENT D with your initial application for licensure.