**Department of Public Health**

**Bureau of Substance Abuse Services**

**APPLICATION FOR APPROVAL OF**

**ADDICTION EDUCATION PROGRAM**

**IMPORTANT:** This document is set up as a protected form. Please fill it out electronically, clicking and/or using the tab key to move from one field to the next, and clicking boxes where checkmarks are required. Once completed, **this form must** **be saved as: AEP Application\_[Program Name]\_[Date]** and emailed to [alex.kearns@state.ma.us](mailto:alex.kearns@state.ma.us). Electronic images of signature pages (printed, signed, and scanned) and attachments should also be saved (with Program Name and Attachment Title) and emailed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Educational Program / Entity Name:** | | | | Check if changed since last renewal/approval: |
| **Educational Program / Entity Main Location Address:** | | | | |
| Street: | | | | Tel: |
| TTY/TDD: |
| City: | State: | | Zip: | Fax: |
| **Educational/Program Entity Mailing Address:**  NOTE: This is the address BSAS will use to send approval and all other notices. | | | | |
| Street: | | | | Tel: |
| TTY/TDD: |
| City: | State: | | Zip: | Fax: |
| **Multiple Physical Locations and/or Distance Learning Options?**  If YES, also complete page 4. | | | | YES  No |
| **Applicant (Corporate) Legal Name** (if different from Educational/Program Entity Name): | | | | |
| **Applicant (Corporate) Mailing Address** (if different from Educational Program/ Entity Mailing Address) | | | | |
| Street: | | | | Tel: |
| TTY/TDD: |
| City: | State: | | Zip: | Fax: |
| **Applicant Organization Type:**  Academic Affiliate or part of *Public* Higher Education Institution (college, junior college or university)  Academic Affiliate or part of *Independent* Higher Education Institution (college, junior college or university)  Free-standing Continuing Education Provider  Specify whether:  For Profit, or  Not for Profit (attach 501 C(3) certificate to Section 1) | | | | |
| Incorporated in (state): | | EIN/TIN: | | |
| **Application For:**  New Approval  Renewal of Existing Approval | | | | |

**CURRENT APPROVALS OR ACCREDITATIONS:** Complete the table below (*for this Educational Program/Entity*). Enter “N/A” if approval or accreditation is not applicable**. Include copies of actual approvals and accreditations for this program in Section 1 of the application.**

If the program contains multiple locations and/or distance learning unit(s) include copies of approvals and accreditations for these locations in Section 1 after the main program documents (e.g., Section 1A for the first physical location or distance learning option, 1B for the second, etc.). Refer to the Overview document for descriptions of each approving body listed here.

|  |  |  |  |  |
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| **APPROVAL BODY** | **Approved Provider Number** | **Current Approval/Accreditation** | | **Initial or Renewal**  **Application In Process** |
| **Start Date** | **Expiration Date** | **Date Submitted** *(leave blank if not in process)* |
| **NASAC:** |  |  |  |  |
| **NAADAC- Academic Education Provider:** |  |  |  |  |
| **NAADAC- Continuing**  **Education Provider:** |  |  |  |  |
| **MA IC&RC PROVIDER**  **(VIA MBSACC):** |  |  |  |  |
| **OTHER:** |  |  |  |  |
| **OTHER:** |  |  |  |  |
| **OTHER:** |  |  |  |  |
| **OTHER:** |  |  |  |  |

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| **TRAINING/EDUCATIONAL PROGRAM PROVIDED** |
| ***[FOR RENEWAL APPLICANTS ONLY: Any changes to program since last renewal/approval?***  **YES**  **NO** *(if no changes, you may skip to* ***Physical Locations/DL Options****)****]*** |
| **NUMBER OF CREDIT HOURS YOUR PROGRAM OFFERS:**  270 CLASSROOM HOURS  300 PRACTICUM HOURS  INDIVIDUAL COURSES OR A CLUSTER OF COURSES – SPECIFY NUMBER OF HOURS**:** |
| Brief description of each program provided: |

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| --- | --- | --- | --- | --- |
| **RESPONSIBLE OFFICIALS** | | | | |
| **Officer of Governing Body:**  *(e.g. president, chairperson of board)* | | **Title:** | | |
| Street Address: | | | Tel: | |
| Fax: | |
| City: | State: | | | Zip: |
| Email address: | | | | |
| **Executive Director/Other Comparable Title:** | | | | |
| Street Address: | | | Tel: | |
| Fax: | |
| City: | State: | | | Zip: |
| Email address: | | | | |
| **Program Director/Other Comparable Title:** | | | | |
| Street Address: | | | Tel: | |
| Fax: | |
| City: | State: | | | Zip: |
| Email address: | | | | |

**Physical Locations and Distance Learning (DL) Options**

Please include copies of all approvals and accreditations for each location/DL option, as applicable, in **Application Documentation** **Section 1**. If there are more than three locations/DL options, copy this page as needed.

|  |  |  |
| --- | --- | --- |
| **Location**   **Distance Learning Option** | | |
| ***FOR RENEWAL APPLICANTS ONLY:***  *Any changes to this physical location/DL option since last renewal/approval* **YES  NO** | | |
| **Location Information** | | |
| Street Address: | Telephone: | |
| City: | State: | Zip: |
| WEBSITE: | | |
| **Person Responsible for this Physical Location/Distance Learning Option:** | | |
| **Services Provided at this Location/by this Distance Learning Option:** | | |

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| **Location**   **Distance Learning Option** | | |
| ***FOR RENEWAL APPLICANTS ONLY:***  *Any changes to this physical location/DL option since last renewal/approval* **YES  NO** | | |
| **Location Information** | | |
| Street Address: | Telephone: | |
| City: | State: | Zip: |
| WEBSITE: | | |
| **Person Responsible for this Physical Location/Distance Learning Option:** | | |
| **Services Provided at this Location/by this Distance Learning Option:** | | |

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| **Location**   **Distance Learning Option** | | |
| ***FOR RENEWAL APPLICANTS ONLY:***  *Any changes to this physical location/DL option since last renewal/approval* **YES  NO** | | |
| **Location Information** | | |
| Street Address: | Telephone: | |
| City: | State: | Zip: |
| WEBSITE: | | |
| **Person Responsible for this Physical Location/Distance Learning Option:** | | |
| **Services Provided at this Location/by this Distance Learning Option:** | | |

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| **ATTESTATIONS and CERTIFICATIONS: *This page must be printed and signed by hand.*** | |
| I/We hereby certify under the penalties of perjury that to the best of my/our knowledge:   * No license or approval held by this applicant to operate any educational or training function in any jurisdiction has been revoked, suspended or limited; * No civil action or criminal charge related to the delivery of service or which may affect continued operation is currently pending against the applicant or any person employed by the applicant; * The program has established All Hazards and Emergency Planning and Procedures; * The program has established policy and procedures for responding to complaints and investigating and reporting incidents of alleged or suspected physical or sexual assault, abuse or neglect; * As required by M.G.L.c. 62C, §49A, the applicant has complied with all laws of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support; * The applicant will comply with the laws of the Commonwealth of Massachusetts, including ADA, and all applicable rules and regulations promulgated by the Department of Public Health and Department of Education; and * The information included in this application and submitted to the Department related to this application is true.   I/We also affirm that I/we have read and am/are familiar with the [105.CMR 168.000 Licensure of Alcohol and Drug Counselor Regulations](http://www.mass.gov/eohhs/docs/dph/regs/105cmr168.pdf), BSAS Mission and Vision, Specific Standards including [Principles of Care, Practice Guidance(s)](http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html) and BSAS [Request(s) for Response](http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/contracting/rfrs.html). I/We understand that incomplete applications will be returned. | |
| **Officer of Governing Body:** | |
| Printed Name | |
| Title | |
| Signature | Date |
|  | |
| **Education/Training Program Director/Responsible Official:** | |
| Printed Name | |
| Title | |
| Signature | Date |

| **Section #** | **Application Documentation** |
| --- | --- |
| **1** | **Proof of Accreditation or Approvals** |
|  | Attach all relevant documentation of Accreditation or Approvals  Label documentation appropriately for each location/DL option, if more than one  (for all items checked under Applicant Organization Type on p. 1) |

| **Section #** | **Application Documentation** |
| --- | --- |
| **2** | **MA Specific Content Requirements – Regulatory Standards (all providers)**  **For descriptions of the items below, see Overview Section III: Massachusetts Standards** |
|  | **Regulatory Standards**  [105 CMR 168.000](http://www.mass.gov/eohhs/docs/dph/regs/105cmr168.pdf) requires 270 Hours of Education prior to licensure as a LADC I or II.  The required hours are delineated as follows. This requirement may be met in its entirety through a complete licensure preparation program or through multiple courses at one or more partial licensure preparation programs. BSAS expects all approved Addiction Education Providers to keep updated about areas of focus and those skills which will be particularly in demand in the field and at BSAS-licensed programs.  For each of the required regulatory content hours, please indicate the Course/s and associated hours. The total hours for a course may be split between multiple areas. If this applies, be careful to ensure that the split hours, when added together, do not exceed the total number of hours for that course. If converting credits to hours, please note that 1 credit is equivalent to 15 hours.  Please put all of your course descriptions (in the form of a course description and syllabus) in a single document, preferably in the order they appear below. Online and In-person versions of the same course should be described separately.  *Renewal Applicants must only document courses if there has been a change since the last application.*  **110 hours related to knowledge of alcoholism and drug abuse.**   |  |  |  |  | | --- | --- | --- | --- | | **Course Name** | **Hours** | **Type of Instruction** | **Description Attached** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **75 hours related to alcohol and drug abuse counseling; assessment; clinical evaluation; treatment planning and case management.**   |  |  |  |  | | --- | --- | --- | --- | | **Course Name** | **Hours** | **Type of Instruction** | **Description Attached** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **75 hours related to patient, family and community education (for alcohol and drugs, HIV/AIDS, infectious diseases, tobacco cessation, etc.); cultural competency and/or other co-existing issues.**   |  |  |  |  | | --- | --- | --- | --- | | **Course Name** | **Hours** | **Type of Instruction** | **Description Attached** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **10 hours related to professional and ethical responsibilities**   |  |  |  |  | | --- | --- | --- | --- | | **Course Name** | **Hours** | **Type of Instruction** | **Description Attached** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

| **Section #** | **Application Documentation** |
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| **3** | **MA Specific Content Requirements - BSAS Specific Standards (all providers)**  Please describe briefly (1-3 sentences) how the courses listed in Section 2 above address the following BSAS Specific Standards. If content is not covered, please check the box marked “not covered.”  **Renewal applicants must only respond if there have been changes since the last application.**  **For descriptions of the items below, see Overview Section III: Massachusetts Standards.** |
|  | ***A. Learning Experience – throughout the program:*** |
| 1. **Describe how your program supports the learning needs of a culturally diverse student body?** |
| 1. **Describe how your program uses Adult-oriented learning approaches:** |
| 1. **Describe how your program provides Quality Clinical Supervision:** |
| 1. **Describe how your program continuously updates its educational content:** |

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|  | ***B. General Content Requirements*** *(separate multiple courses with semi-colons, not paragraphs)* |
| 1. **Addiction** covered comprehensively Not covered   Covered in course/s: |
| Brief Description: |
| 1. **All stages of substance use** Not covered   Covered in course/s : |
| Brief Description: |
| 1. **Addiction approached as a chronic disease** Not covered   Covered in course/s : |
| Brief Description: |
| 1. **Evidence Based Practices** are included Not covered   Covered in course/s : |
| Brief Description: |
| 1. **Adaptations** of techniques for particular populations Not covered   Covered in course/s : |
| Brief Description: |
| 1. **Prevention and Treatment** approached as collaborative activities Not covered   Covered in course/s : |
| Brief Description: |
| ***C. Specific Content Requirements*** *(separate multiple courses with semi-colons, not paragraphs)* |
| 1. **Basic Concepts of Addiction** |
| * 1. ***Pharmacology/Neurobiology*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Tobacco*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Compulsive Gambling***is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***BSAS Levels of Care*** are covered in the following course/s: Not covered |
| Brief Description: |

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|  | 1. **Ensuring Quality Care** |
| * 1. ***Consumer/Client Rights*** are covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Ethics and Boundaries***are covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Culturally and Linguistically Appropriate Services (CLAS)***are covered in the following course/s:       Not covered |
| Brief Description: |
| * 1. ***Self-care*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Evaluation of Service Delivery*** is covered in the following course/s: Not covered |
| Brief Description: |
| 1. **Providing Client-Centered Care** |
| * 1. ***Culturally Competent Care*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Trauma Informed Care* i**s covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Medication assisted treatment*** is covered in the following course/s Not covered   (Including but not limited to: methadone, buprenorphine and naltrexone) |
| Brief Description: |
| * 1. ***Family Issues/Involvement*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Age-Specific/Developmentally Appropriate Services*** are covered in the following course/s:   Not covered |
| Brief Description: |

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|  | * 1. ***Gender-Specific Services*** are covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Behavior management*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Safety*** is covered in the following course/s: Not covered |
| Brief Description: |
| 1. **Understanding Prevention, Intervention and Outreach Strategies** |
| * 1. ***Prevention*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Intervention*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Opioid Overdose Reversal***is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Outreach*** is covered in the following course/s: Not covered |
| Brief Description: |
| 1. **Supporting Recovery** |
| * 1. ***Self-help*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Medication*** is covered in the following course/s: Not covered   (Including but not limited to: methadone, buprenorphine and injectable naltrexone) |
| Brief Description: |
| * 1. ***Culture of Recovery*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Responses******to******relapse*** is covered in the following course/s: Not covered |
| Brief Description: |
|  | 1. **Addressing Related Health Needs** |
| * 1. ***Co-occurring Conditions*** are covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Holistic and nutritional approaches to recovery*** are covered in the following course/s:   Not covered |
| Brief Description: |
| * 1. ***Infectious Disease*** is covered in the following course/s: Not covered |
| Brief Description: |
| * 1. ***Integrated Care*** is covered in the following course/s: Not covered |
| Brief Description: |

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| **Section #** | **Application Documentation** |
| **4** | **Counseling Practicum** |
|  | 105 CMR 168.000 requires a 300 hour supervised counseling practicum. Of the 300 total hours each of the 12 core functions must be performed for a minimum of 10 hours and a minimum of one hour of face to face supervision to 10 hours of practical experience must be provided. |
| 1. Does your program provide a **300 hour practicum**?  YES  NO |
| 2. Does your program have **formal agreement(s) with the practicum provider(s)**?  YES  NO  If yes, please attach copies of each.  Copies attached |
| 3. Please **affirm and describe how your program typically evaluates practicum providers** in terms of: |
| **Supervision**\*: |
| **Appropriateness of the placement**: |
| **Student evaluation by practicum provider**: |
| 4. Please describe the type and frequency of communication between your program and practicum provider: |

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| **Section #** | **Application Documentation** |
| **5** | **Hiring Standards/Policy** |
|  | While BSAS does not control the applicant’s hiring decisions, the description/policies will be reviewed for evidence that the applicant education/training entity requires:   * Up-to-date knowledge and experience to teach the substance use and addictions content * Appropriate educational background (Master’s degree in a relevant field or equivalent experience) * Appropriate licensures and certifications * Positive References * Consideration of CORI information * Periodic evaluation of instructors |
| **Please describe your hiring standards for instructors:** |
| **Relevant policies related to qualifications of instructors attached?**   YES  NO |

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| --- | --- |
| **Section #** | **Application Documentation** |
| **6** | **Advertising/Marketing Materials** |
|  | **Please attach a copy of any advertising/marketing materials,**  **demonstrating how you market and advertise your program(s)**  **(can include brochures, web links, etc.)** |

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| **Section #** | **Application Documentation** | |
| **7** | **Agreement to Update Information – please print and sign by hand** | |
|  | On behalf of the Applicant, I agree to update BSAS within five (5) business days of any substantive changes to the information provided in this Application, prior to and following approval of the Application. Examples: changes in responsible officials, course content, hours, delivery methods, standards for instructors. | |
| Name  *Program Director/Responsible Official* | |
| Signature | **Date** |