

Bureau of Substance Addiction Services (BSAS)
Notice of Intent to Apply for a Substance Use Disorder Treatment Program License Checklist

Prior to submission of the NOI to the Department, you are encouraged to contact your [regional licensing inspector](#) in addition to reviewing and initialing the checklist below to ensure that a completed application with all required documentation is being submitted.

	Agency Initials	Department Use Only
Confirmation of meeting with regional licensing inspector and/or assistant director of licensing		
Confirmation of regulatory review, including regulatory requirement for proposed service setting(s)		
Proposed Programs & Services section complete		
Responsible Officials section complete		
Organization chart(s) included		
Articles of Incorporation and bylaws included		
All Proposed Services questions answered		
All Demonstration of Need questions answered		
All History of Providing Services questions answered		
All Disciplinary History questions answered		
Affirmations initialed		
Application notarized		

Bureau of Substance Addiction Services (BSAS)
Notice of Intent to Apply for a Substance Use Disorder Treatment Program Certification of Approval That Holds a License from the Bureau of Health Care Safety & Quality (BHCSQ)

As required by 105 CMR 164.000 Licensure for Substance Addiction Treatment Programs, BSAS is required to assess the suitability of entities or organizations seeking a license or certificate of approval for the provision of substance use treatment services as well as for the need for the service(s). The following form has been created to assist you in providing the information and documents necessary to determine the suitability and need for 105 CMR 164.500. Submission of these documents fulfills the requirement of submitting a notice of intent.

IMPORTANT: Please complete the following form. Please scan and submit the completed form and all required documents to Sarah Tantillo, QAAL Program Coordinator at Sarah.Tantillo@mass.gov.
Note: The form is electronic and fillable. Hand-written submissions will not be accepted.

Organization Name:

Organization Type:

Incorporated in (State & Date):

EIN/TIN:

Organization Address (including City, State & Zip Code):

Organization Website:

Check if merging with/transfer of ownership of a currently licensed BSAS Program: Yes No

BSAS License #(s):

Name of currently licensed organization/program(s):

Part 1 – Proposed Program and Services Information

Proposed Program Name:

Proposed City/Town where services will be offered:

Do you have control over the site where services will be provided: Yes No

Program website (if different from agency):

Immediate Services to be Provided by the Program Within the First 6 Months

Proposed Population(s): Adults Transitional Aged Youth Adolescents

Total Number of Beds:

24-Hour Diversionary Services (164.100)

Medically Managed Withdrawal Treatment

Clinical Stabilization Services

Opioid Treatment Programs (164.300)

Opioid Treatment Program (Community-Based)

Outpatient Services (164.200)

Counseling

Driver Alcohol Education (DAE)

Operating Under the Influence Offender Aftercare (SOA)

Office Based Opioid Treatment (OBOT)

Residential Rehabilitation (164.400)

Residential Rehabilitation

Residential Rehabilitation for Adults with their Families

Co-Occurring Enhanced

Residential Programs for Operating Under the Influence Second Offer

Day Treatment

Outpatient Withdrawal Services

Acupuncture Withdrawal Management Services

Part 2- Responsible Officials
Reference 105 CMR 164.030 regarding board members.

Primary Contact for the NOI

Name:

Email:

Senior Officers of Governing Body- Please name all senior officers on a separate sheet if multiple

Name:

Email:

Medical Director- *Required for 24-Hour Diversionary, Outpatient Withdrawal Management, and OTP Services*

Name:

Email:

Part 3- Legal Capacity to Operate

Please submit the following information:

1. An organization chart that includes any parent/grandparent organizations associated with this agency and describes the relationships and types of business as well as an organization chart that depicts specific roles within the proposed program. Please attach any corporate structure documents, and
2. A copy of your Articles of Incorporation and Corporate Bylaws

Affirmations

I/We affirm that we have read and understand the following (please initial):

I understand and affirm that the information included in this Notice of Intent to Apply and submitted to the Department related to this Notice of Intent to Apply is true.

I understand and agree to abide by the laws of the Commonwealth of Massachusetts that apply to operating a business in Massachusetts, including 105 CMR 164.000. I also understand and agree to abide by all other applicable, related state and federal laws, including the Americans with Disabilities Act, 42 CFR Parts 2 & 8, and 45 CFR Parts 160 & 164.

I understand and agree to comply with 105 CMR 164.009(B)(1) and the CARE Act of 2018 and provide access to program services to all individuals, including those with public insurance on a nondiscriminatory basis.

I understand and affirm that the organization is eligible to contract with public insurance. *If the agency is unable to affirm, please provide a detailed explanation.*

I understand that it is the expectation of the Department referenced in 105 CMR 164.009(B)(2) that the program offers access to all forms of FDA-approved medications for addiction treatment on a nondiscriminatory basis.

I understand and agree to the terms referenced in 105 CMR 164.019, which note that the Department does not guarantee licensure or approval, even if an application is accepted. If the proposed program(s) are not able to demonstrate compliance, a license will not be issued. The costs associated with licensure or approval are the sole responsibility of the entity seeking licensure or approval and payment of such costs does not guarantee licensure or approval.

I understand and agree to implement Trauma Informed Care in the proposed substance use treatment program. For additional information please see the [Trauma Informed Care Practice Guidance](#).

I understand and agree to incorporate the national standards for Culturally and Linguistically Appropriate Services (CLAS). For additional information please see DPH's [Culturally and Linguistically Appropriate Services \(CLAS\) Initiative webpage](#).

Note: Once the Notice of Intent to Apply Form and required documents have been submitted and reviewed, the primary contact, as listed on this form, will be sent notification of the status of approval. If approved, instructions on how to access the e-licensing application, which sits on the Virtual Gateway, will be sent along with the contact information of the Licensing Inspector of the region where the program will be sited.

Signatures

SIGNED UNDER THE PENALTIES OF PERJURY, this _____ day of _____, 20_____.

Applicant or Authorized Agent's Signature _____

Applicant or Authorized Agent's Printed Name and Title _____

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public:

Seal

My commission expires on _____, 20_____