

Massachusetts Department of Public Health (DPH)
Bureau of Substance Addiction Services (BSAS)

**NOTICE OF INTENT TO APPLY FOR A
SUBSTANCE USE DISORDER TREATMENT PROGRAM LICENSURE
FOR AN ENTITY THAT CURRENTLY HOLDS A LICENSE FROM DMH**

As required by **105 CMR 164.000 Licensure of 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. The following form has been created to assist you in providing the information and documents necessary to determine suitability and need **per 105 CMR 164.509 and 164.511**. 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.

Organization Name:

Organization Type: Currently Licensed by DMH

Include a copy of your DMH license with submission*

Incorporated in (state and date):

Registered in Mass.:

EIN/TIN:

Organization Address:

Mass. Sec. of State:

Organization City:

TTY/TDD #:

Organization State:

Organization Phone Number:

Organization Zip Code:

Organization Email:

Organization Website:

Check if merging with/transfer of ownership of a currently BSAS licensed agency:

BSAS License #(s):

Name of Program(s):

Part One- Proposed Program and Services

Proposed program name:

Do you have control over the site where proposed services will be provided:
(if yes, please list address/addresses below; if no describe status and timeline of acquiring control)

Program Address:

Program City:

State:

Zip Code:

Program website:

Status and timeline of acquiring site control:

Proposed population(s) to be served: Adults Adolescents Transitional Aged Youth

Proposed number of beds if applicable:

Proposed services to be offered:

24-Hour Diversionary Services

Medically Managed Withdrawal Treatment
(Requires Hospital License)

Medically Managed Withdrawal Treatment

Clinical Stabilization Services

Residential Rehabilitation

Residential Rehabilitation for Adults

Residential Rehabilitation for Adults with their families

Residential Rehabilitation for Adolescents

Residential Rehabilitation for Transition Age Youth

Residential Programs for Operating Under the Influence Second Offender Programs

Co-Occurring Enhanced Residential

Opioid Treatment Programs

Opioid Treatment Program for detoxification & maintenance (OTP)

Outpatient Services

Counseling

Driver Alcohol Education (DAE)

Operating Under The Influence Offender Aftercare (SOA)

Acupuncture Withdrawal Management Services Office

Based Opioid Treatment(OBOT)

Day Treatment

Outpatient Withdrawal Services

Mental Health Services

Part Two- Responsible Officials

Please reference 105 CMR 164.030 regarding board members

Any position marked with an * requires a resume to be submitted with the NOI packet.

Primary Contact for NOI

Name:

Email Address:

Owner(s)- *If more than one attach sheet with information and provide org. chart*

Name:

Email Address:

Street Address:

Phone Number:

State:

% of Ownership:

Zip Code:

Executive Director*

Name:

Email Address:

Street Address:

Phone Number:

State:

Zip Code:

Senior Officers of Governing Body*- *Please name all senior officers on a separate sheet with the below required information (e.g. president, director, chairperson of board, CEO, COO, CFO, CCO)*

Name and Title:

Email Address:

Street Address:

Phone Number:

State:

Zip Code:

Medical Director*- *required for 24 Hour Diversionary or Outpatient Withdrawal Management Services or OTP*

Name:

Email Address:

Street Address:

Phone Number:

State:

Zip Code:

The following narrative responses pertain to the Licensed Provider/Applicant as defined below: Licensed Provider - any entity, including its controlling parent (corporation) holding a license from the Department to operate a substance use disorder treatment program. In the case of a Licensed Provider which is not a natural person, the term Licensed Provider shall also mean any shareholder owning 5% or more of the outstanding stock; any limited partner owning 5% or more of the partnership interests and any general partner of a partnership Licensed Provider; any trustee of any trust Licensed Provider; any receiver or trustee in bankruptcy; any manager of a Limited Liability Company and any member of a Limited Liability Company with a 5% or more membership interest; any sole proprietor of any Licensed Provider which is a sole proprietorship; any mortgagee in possession; and any executor or administrator of any Licensed Provider which is an estate.

Part Three- Narrative Responses

1. Proposed Services and Expertise - Please submit a brief narrative describing:

a. The services you are proposing and target population(s) to be served.

b. The estimated number of patients/residents to be served.

e. How these services will link to the continuum of care as referenced in 105 CMR 164.005; Describe how you have reached out to the community this service is being established in, concerns raised, and how you will address concerns. *Not applicable to those Providers who been deemed to contract with the Department per 105 CMR 164.011 (A-B).*

f. The agency's expertise in providing substance use disorder treatment, and, specifically, the agency's expertise providing services in the service setting being proposed.

g. In accordance with 105 CMR 164.074 how will medication assisted treatment, including all FDA approved medications for opioid use disorder be incorporated into the proposed program? Please describe this treatment planning process beginning with admission through discharge, and including aftercare planning. *If you intend to provide withdrawal management services, submit the resume of the Medical Director.*

h. What evidence-based practices will be implemented in the proposed program as referenced in 105 CMR 164.074?

2. History of Providing Services - Please describe the following for any entity in Massachusetts and/or any other state or jurisdiction: (Please include information pertaining to any individual or entity responsible for this service as described above in the Licensed Provider definition.)

a. Any history of directly providing any substance use disorder treatment services or other health care services and/or any direct involvement in operations of a substance use disorder treatment services or other health care services;

b. Any current or pending licenses and current or pending accreditation as a provider of substance use disorder treatment or other health services;

c. Any history of acting without the appropriate license(s); Any history of failure to provide services to any individual when licensed or approved to provide such services that may or may not have resulted in disciplinary action; Any history of patient/resident abuse, mistreatment or neglect in any licensed health care program or facility;

d. Has any state or federal agency taken any action against any of the operating sites which restricted the ability to operate; if yes, please describe;



e. List any active investigations by state, federal, and/or any other authority agencies.
List any current investigations and any and all closed investigations in the last 24 months.

f. Any ongoing and/or civil or criminal investigations that resulted in settlement/judgment/
conviction brought against the applicant, board members, or responsible party which is
related to the delivery of services.

3. Financial Viability - Demonstrate the ability for the service to be financially viable for at least the provisional and full licensing period (2 ½ years minimally.) Please submit the following:

- a. Your Agency's most recent financial audit (including your most recent financial statement, cash flow statement and balance sheet);
- b. A statement that affirms that the provided bank funds can be used for the program and or services to be provided
- c. A business plan for the new service and proposed operating budget;
- d. Documentation of sufficient cash/assets to support start-up such as a bank statement or letter showing sufficient funds to cover the expenses laid out in start-up projections;
- e. Evidence of any third party payers/insurers you have relationships with and any other sources of revenue and sources of referrals;
- f. List any proposed third party payers or insurers (including public insurers) with whom you plan to engage in a relationship for referral or revenue.

4. Legal Capacity to Operate. Please submit the following:

- a. Submit a copy of your Articles of Incorporation and Corporate By-Laws;
- b. If this entity is part of a larger business structure/entity, describe the relationship and types of businesses and submit org chart showing relationship;
- c. State what states these entities operate in;
- d. Submit a list of owners and executive board, their resumes, and signed consent forms (attached) for Criminal Offender Record Check (CORI) review.

BSAS Expectations:

In accordance with 105 CMR 164.000 DPH licensed facilities must be compliant with state and federal ADA regulations. Licensed substance use treatment services are expected to provide culturally and linguistically appropriate services (BSAS has multiple Practice Guidance documents, such as Making Treatment Culturally Competent on its website as resources (www.mass.gov/dph/bsas); and the DPH Office of Health Equity also has applicable materials, such as the manual CLAS Happens (www.mass.gov/healthequity)).

Part Four- Affirmations

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

I understand and agree to abide by the laws of the Commonwealth of Massachusetts that are applicable to operating a business in Mass., 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 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. Any omission of material information or submission of false or misleading information will be grounds for denial of licensure. 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 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 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 that it is the expectation of the Department referenced in 105 CMR 164.000 that the program offers access to all forms of FDA approved medications for opioid use disorder on a nondiscriminatory basis.

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 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_____

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NOI Received:

NOI Reviewed:

Denial Reason (if applicable):

Additional Information Requested:

Additional Information Requested:

Determination:

Date Deemed Suitable:

Determination Letter/ VG Access Information Sent: