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

Before submission of the NOI to the Department, you are encouraged to review the resources available online 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 regulatory review, including regulatory requirements for proposed service setting(s)		☐
Proposed Programs & Services section complete		☐
Responsible Officials section complete		☐
Resumes & CORIs for **all** responsible officials included		☐
Organizational 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		☐
All required Financial Viability documents included		☐
Affirmations initialed		☐
Application notarized		☐

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

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 and 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 per 105 CMR 164.009(A) (1-10) and 164.011(A). Submission of these documents fulfills the requirement of submitting a notice of intent.

IMPORTANT: The applicant shall have the sole burden to demonstrate the applicant's suitability.

Please complete the following form. Please scan and submit the completed form and all required documents to bsas-noi-suitability@mass.gov as a single document.

The form is electronic and fillable. Handwritten submissions will not be accepted.
Incomplete applications will not be reviewed and will be returned.

Organization Name:	Organization Type
Incorporated In (State & Date)	EIN/TIN:
Organization Address (City, State & Zip Code):	
Organization Website:	
If this NOI submission is related to a **Transfer of Ownership**, please complete the Transfer of Ownership Notice of Intent here, instead of this form.	

Part 1 – Proposed Program & Services Information

Proposed Program Name:

City/Town where services will be offered:

Confirmation of site control for service location: Yes No

The Department requires all applicants to have established site control before receiving suitability approval. Please do not submit the Notice of Intent (NOI) until site control has been secured.

Please indicate whether the property is owned or leased: Owned Leased
Please indicate whether the agency has received any necessary city/town approvals and/or zoning is approved for the intended use. Yes No

Immediate Services to be Provided by the Organization <u>Within the First 6 Months</u>
(Please select all that apply)

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

Residential Rehabilitation (164.400)

☐ Residential Rehabilitation

☐ Residential Rehabilitation for Adults with their Families

☐ Co-Occurring Enhanced

☐ Residential Programs for Operating Under the Influence Second Offender

Outpatient Services (164.200)

☐ Counseling

☐ Driver Alcohol Education (DAE)

☐ Operating Under the Influence Offender Aftercare (SOA)

☐ Office-Based Opioid Treatment (OBOT)

☐ Day Treatment

☐ Outpatient Withdrawal Services

☐ Acupuncture Withdrawal Management Services

Part 2- Responsible Officials

Reference 105 CMR 164.030 regarding board members.

Primary Contact for NOI

Name: **Email:**

Owner(s) & Responsible Officials

Resumes and CORIs must be submitted for all parties listed in the table below.

Name	**Title/Role** (i.e., Owner, Executive Director, Medical Director, Senior Clinician, Program Director, Governing Body Members)	**Total Ownership %** If applicable

Part 3- Legal Capacity to Operate

Please submit the following:

1. A list of owners and responsible officials, their resumes, and signed consent forms for Criminal Offender Record Check (CORI) review
2. An organization chart that includes any parent/grandparent organizations associated with this organization and describes the relationships and types of business, and an organization chart that depicts specific roles within the proposed program. Please attach any corporate structure documents
3. A copy of your Articles of Incorporation and Corporate Bylaws

Part 4- Financial Viability

Demonstrate the ability for the service to be financially viable
for at least the term of the initial license (6 months)

Please submit the following:

1. A business plan for the new service and proposed operating budget,
2. Level of funding to cover the cost with sufficient detail, including bank statements and/or proof of capital or loan,
3. Projections of revenues, costs, and expenses, and the fiscal management plan,
4. Line items of the profits & losses,
5. A list of any proposed third-party payers or insurers (including public insurers) in which you plan to engage in a relationship for referral or revenue.

Part 5- Narrative Questions

1. Proposed Services

a. Describe the proposed service(s) to be offered, the estimated size of the program, and the priority populations to be served within the first 6 months of operation.

b. Describe how medication for addiction treatment will be incorporated into the proposed service(s), including **all** forms of federally approved medications for opioid use disorder per 105 CMR 164.074.
Please identify which addiction treatment medications will be provided directly by the program and which will be offered through a Qualified Service Organization Agreement (QSOA), including the name(s) of the QSOA partner(s).

c. Describe the organization's plan to recruit and retain the regulatorily required positions that are representative of the population and community served.

2. Demonstration of Need of Proposed Services

a. Describe why the **proposed service(s)** and **geographical area** were determined, including an analysis of qualitative and quantitative data that supports the specific need for the proposed service(s) in the identified community, not the county or state.

b. Describe how the **proposed service(s)** will fulfill an unmet need in the identified geographic area by eliminating any existing barriers to treatment in the proposed community.

c. Describe how the proposed organization will collaborate and coordinate care with existing Substance Use Disorder (SUD), Recovery Support, Harm Reduction and health care providers within the identified geographic area. Identify which specific agencies you intend to work with and describe how these collaborations will improve patient care and ensure access to a full continuum of care.

d. Describe the impact these proposed services(s) will have on existing SUD and health care providers in the identified geographic area.

e. Describe how the program will deliver effective, understandable, and respectful care that is provided in a manner consistent with a patient's or resident's cultural health beliefs and practices and preferred language. Please describe your program's strategies for delivering culturally competent and linguistically appropriate services.

f. Describe how the entity will provide services for individuals with public health insurance, including Medicaid, on a nondiscriminatory basis

3. Organization & Named Officials: History of Providing Services

a. Describe the **organization's** experience directly or indirectly providing or operating the following:

i. Any substance use disorder treatment, including proposed service(s) listed.

ii. Any clinical or direct care experience in the **proposed service(s) listed**.

iii. Any health care services/ mental health services not identified in part i.

b. Describe any **owners and any named official's** experience directly or indirectly providing or operating the following:

   i. Any substance use disorder treatment, including proposed service(s) listed.

   ii. Any clinical or direct care experience in the **proposed service(s) listed**.

   iii. Any health care services/ mental health services not identified in part i.
   Click or tap here to enter text.

c. Please identify any SUD or health care services that the organization and any named officials are associated with in Massachusetts as well as any other states. Provide a copy of licensure or other supporting documents for out-of-state SUD/health care services.

4. Organization & Named Officials: History of Providing Services: Disciplinary History

a. Describe the **organization's** disciplinary history of the following:

i. Any past instances of acting without appropriate licensure, any history of failure to provide appropriate services, and any history of patient/resident abuse, mistreatment, or neglect in any health care program that did or did not result in disciplinary action.

ii. Any state or federal agency action taken resulting in the restriction of a program's ability to operate.

iii. Any active and/or closed investigations conducted by state or federal agencies and/or any other authorities (such as local police) within the last 24 months.

iv. Describe any ongoing or closed civil and/or criminal investigations related to the delivery of services. If closed, describe the disposition of the closure, including whether the investigation resulted in a settlement/judgment/conviction against the entity or any owner or individual named on this application.

b. Describe any **owners' and named officials'** disciplinary history of the following:

i. Any past instances of acting without appropriate licensure, any history of failure to provide appropriate services, and any history of patient/resident abuse, mistreatment, or neglect in any health care program that did or did not result in disciplinary action.

ii. Any state or federal agency action taken resulting in the restriction of a program's ability to operate.

iii. Any active and/or closed investigations conducted by state or federal agencies and/or any other authorities (such as local police) within the last 24 months.

iv. Describe any ongoing or closed civil and/or criminal investigations related to the delivery of services. If closed, describe the disposition of the closure, including whether the investigation resulted in a settlement/judgment/conviction against the entity or any owner or individual named on this application.

Affirmations

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

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 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_____