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: --Select--

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

Part 4- Narrative Questions

1. **Proposed Services**

   a. Describe the proposed service(s) to be offered, the estimated size of the program and the applicable special 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. Will the proposed service(s) offer medications for addiction treatment directly or through a service agreement with a licensed provider?

   c. Describe the agency'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.

b. Describe how the proposed service(s) will fulfill an unmet need in the identified geographic area.

c. Describe how the proposed program will collaborate and coordinate care with existing SUD and health care

d. Describe how health disparities will be addressed through access to services for underserved populations and persons with co-occurring mental health conditions and substance use disorder.

3. History of Providing Services

a. Describe the organization's (including the individuals named in the application) experience directly or indirectly providing or operating any substance use disorder treatment and/or health care services.

b. Describe the organization's (including the individuals named in the application) experience directly or indirectly providing the proposed service(s).

c. Identify any other states where the organization (including the individuals named in the application) currently operates a licensed or accredited substance use disorder treatment program and provide a copy of licensure or other supporting documents.

4. **Disciplinary History related to the organization (including the individuals named in the application)**

   a. Describe 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.

   b. Describe any state or federal agency action taken resulting in the restriction of a program's ability to operate.

   c. Describe 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.

   d. 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 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):

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_____