

Bureau of Substance Addiction Services (BSAS)

Notice of Intent for Transfer of Ownership

105 CMR 164.000 Licensure for Substance Addiction Treatment Programs defines a transfer of ownership as a transfer of a majority interest in the ownership of the substance use disorder treatment program; it also means any change in the ownership interest or structure of a substance use disorder treatment program or the program's parent corporation(s) that the Commissioner determines to effect a change in the control of the operation of the substance use disorder treatment program.

At least 90 calendar days in advance of any transfer of ownership, any applicant who intends to acquire a substance use disorder treatment program shall submit a Notice of Intent to the Department on a form supplied by it. The Department shall notify each applicant in writing of the date on which the form is deemed completed. Within 90 calendar days of such date, the Department shall complete its suitability review for licensure pursuant to the standards of 105 CMR 164.009.

CIRCUMVENTION: A transfer of ownership shall not be recognized, and the new owner shall not be considered suitable for licensure when the Transfer of Ownership is proposed or made to circumvent the effect and purpose of 105 CMR 164.000. The Department shall consider the following factors in determining whether a Transfer of Ownership has been proposed or made to circumvent 105 CMR 164.500: (1) The transferor's record of compliance with Department licensure laws and regulations; (2) The transferor's current licensure status; (3) The transferor's familial, business or financial relation to the transferee; and (4) The terms of the transfer.

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

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

Incomplete applications will not be reviewed and will be returned.

New Entity Information	
Organization Name:	Organization Type:
Incorporated in (State & Date):	EIN/TIN:
Organization Address (including City, State & Zip Code):	
Organization Website:	
Existing Entity (Currently Licensed Program/Entity) Information	
Program Name:	BSAS License #:
Program Address:	

Part 1- Proposed Program & Services Information

Affirmation that there will be no change in the services or location of the current program

Part 2- Responsible Officials

Please note: NOI submissions that do not include pre- and post-transfer of ownership organizational charts will not be considered complete submissions and will not be reviewed.

Primary Contact for NOI

Name:

Email:

Owner(s) & Responsible Officials of the New Ownership, including any other holding/operating held by any listed individuals that provide SUD, health care, or MH services

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, C-Suite Leadership (CEO, CFO COO), Governing Body Members)	Staying During Transition (Yes/No)	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 copy of the purchase agreement and any other documentation related to the transfer of ownership
2. A business plan for the new service and proposed operating budget,
3. Level of funding to cover the cost with sufficient detail, including bank statements and/or proof of capital or loan,
4. Projections of revenues, costs, and expenses, and the fiscal management plan,
5. Line items of the profits & losses,
6. 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 4- Narrative Questions

1. Proposed Services

- a. Describe the services that are currently being offered, including the program size and priority populations. Describe any anticipated changes to services that may be offered, updated, and or changed as a result of the transfer.
- b. Describe any anticipated interruptions of services.
- c. 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).

- d. Describe the staffing plan during the transition, including the responsible officials, and identify if they will be staying during the transition.
- e. Describe the organization's plan to recruit and retain the additional regulatorily required positions who are representative of the population and community served.
- f. Describe the nature of the transfer, including the management services agreement, if available, and any other documents related to the transfer of services.

2. Demonstration of Need of Proposed Services

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