



MARYLAND  
Department of Health

**Addendum Cover Page for Maryland  
Medical Assistance Program Application  
FACILITY/ORGANIZATION**

**PT 54 IMD RESIDENTIAL SUD ADULT**

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**  
**Monday – Friday from 7am – 7pm.**

All providers are required to use the electronic Provider Revalidation and Enrollment Portal, or ePREP ([eprep.health.maryland.gov](http://eprep.health.maryland.gov)) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the “Additional Information” section under “Practice Information” within the ePREP ([eprep.health.maryland.gov](http://eprep.health.maryland.gov)) “Applications” tab, along with any additional documents requested within the addendum.

**Provider Information**

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

**After you receive your Medical Assistance enrollment approval,  
please register with Beacon Health Options for authorization.**

To register:

1. Visit <http://maryland.beaconhealthoptions.com/index.html>
2. Click on “Behavioral Health Providers”
3. Click on “Register”
4. Complete the Provider Online Services Registration form that appears

Should you have any questions regarding Beacon Health Options registration, please contact:  
Beacon Provider Relations: Phone: (800) 888-1965 – Email: [marylandproviderrelations@beaconhealthoptions.com](mailto:marylandproviderrelations@beaconhealthoptions.com)

Please visit [health.maryland.gov/ePREP](http://health.maryland.gov/ePREP) for more information about ePREP



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\* In order to enroll as an IMD Residential SUD Adult provider you must have a license issued by the Behavioral Health Administration that includes at least one of the following levels of care:

- Level 3.1 \* Medicaid will begin reimbursing this level of care effective 1/1/2019. You may now submit applications\*
- Level 3.3
- Level 3.5
- Level 3.7
- Level 3.7 WM

\*If you have not yet been issued a license by the Behavioral Health Administration (BHA), be sure to upload one of the following documents to ePREP:

- 1) Approval letter from the Behavioral Health Administration (BHA) that lists at least one of the required levels of care

**Only an option for revalidations:**

- 2) Continuation letter from the Behavioral Health Administration (BHA) **AND** a copy of the expired approval letter or license under 10.47 that lists at least one of the required levels of care

**Section I:**

Please upload the following document to [ePREP](http://eprep) :

1. Completed Adult Residential SUD Provider Attestation Form (attached)
2. License and credentials of all professional employed by or under or under contract with the provider. **COMAR 10.09.06.04**
3. Pre-employment criminal history records for each employee. **COMAR 10.63.01.05**
4. Written policy regarding the criminal history of the program’s employees, contractors, and volunteers. **COMAR 10.63.01.05**



**At a minimum, includes consideration of the following:**

- (a) The age at which the individual committed the crime;
- (b) The circumstances surrounding the crime;
- (c) Any punishment imposed for the crime, including any subsequent court actions regarding that punishment;
- (d) The length of time that has passed since the crime;
- (e) Subsequent work history;
- (f) Employment and character references; and
- (g) Other evidence that demonstrates whether the employee, contractor, or volunteer poses a threat to the health or safety of a program participant, program staff, or a member of the public.

**Please note:**

(4) An individual may not be hired as an employee, contractor, or volunteer:

- (a) For a program serving participants younger than 18 years old, if the individual has been convicted at any time of child abuse or child sexual abuse; or
- (b) For a program serving participants 18 years old or older, if the individual has been convicted at any time of abuse or neglect of a vulnerable adult



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

## **Adult Residential SUD Provider Attestation Form**

*ASAM Levels 3.3 to 3.7-WM (3.1 effective 1/1/2019)*

**Program/Facility Name:** \_\_\_\_\_

**Facility Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_

**License Number:** \_\_\_\_\_

Maryland Department of Health (“the Department”) program requirements follow the criteria defined by the American Society of Addictions Medicine (ASAM) for the provision of substance use disorder treatment services. Providers shall have a current version of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed.*, and provide services that meet these criteria.

If your organization meets a specific level of care based on the ASAM Criteria, and have trained and knowledgeable staff in applying the ASAM Criteria, you must complete this Provider Attestation Form and any additional required credentialing and/or contracting documents.

The Department will inform you if you meet the requirements to be enrolled or credentialed as a Medicaid provider. Attesting to meeting ASAM Criteria does not guarantee enrollment as a Medicaid provider.

### **Program Requirements**

By signing this attestation you certify that the program has an active Behavioral Health Administration issued-license and complies with all relevant Department regulations including but not limited to COMAR 10.09.36 and COMAR 10.63.

**Program Types**

By marking “Yes” you attest that the following ASAM Levels of Care (LOC) are offered at your facility, that you have received licensure from the Office of Health Care Quality for each LOC, and that you are compliant with all applicable Department regulations for the LOC indicated.

Program Type	ASAM LOC	Provide Service	
		Yes	No
<p><b>Clinically Managed Low-Intensity Residential Services</b> Clinically Managed Low-Intensity Residential Services, provides a 24 hour living support and structure with available trained personnel, and offers at least 5 hours of therapeutic services a week.</p>	<b>3.1</b>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Residential Medium Intensity Program</b> Clinically-managed substance-related disorder treatment based on a comprehensive assessment. Provides services in a structured environment in combination with medium-intensity treatment and ancillary services to support and promote recovery.</p>	<b>3.3</b>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Residential High Intensity Program</b> Clinically-managed substance-related disorder treatment based on a comprehensive assessment. Provides services in a highly-structured environment, in combination with moderate- to high-intensity treatment and ancillary services to support and promote recovery;</p>	<b>3.5</b>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Residential Intensive Program</b> Provide medically-monitored, intensive substance-related disorder treatment based on a comprehensive assessment. Offers a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting;</p>	<b>3.7</b>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Withdrawal Management Service</b> Offers 24-hour medically supervised evaluation and withdrawal management.</p>	<b>3.7-WM</b>	<input type="checkbox"/>	<input type="checkbox"/>



**Staffing**

By marking “Yes” you attest that the program employs, at minimum, the following staff:

ASAM Level 3.1 (effective 1/1/2019)	Employed Staff	
	Yes	No
Program Director on-site 20 hours/week	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Director on-site 20 hours/ week (may also serve as the Program Director)	<input type="checkbox"/>	<input type="checkbox"/>
Licensed or certified counselor on-site 40 hours/ week	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Staff (Recovery Coach)	<input type="checkbox"/>	<input type="checkbox"/>
Aftercare Coordinator	<input type="checkbox"/>	<input type="checkbox"/>

ASAM Level 3.3	Employed Staff	
	Yes	No
Physician, NP and/or PA (on-site 4 hours/week, 1 hour on call)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist or Psychiatric NP (available 3 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse RN or LPN (on-site 40 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Facility Director (on-site 20 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Supervisor	<input type="checkbox"/>	<input type="checkbox"/>
Certified Counselors (Clinical SUD)	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Mental Health Clinician	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Staff (Recovery Coach)	<input type="checkbox"/>	
Aftercare Coordinator	<input type="checkbox"/>	

ASAM Level 3.5	Employed Staff	
	Yes	No
Physician, NP and/or PA (on-site 1 hour a week)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist or Psychiatric NP (available 1 hour a week)	<input type="checkbox"/>	<input type="checkbox"/>
Facility Director (on-site 20 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Supervisor	<input type="checkbox"/>	<input type="checkbox"/>
Certified Counselors (Clinical SUD)	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Mental Health Clinician	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Staff (Recovery Coach)	<input type="checkbox"/>	<input type="checkbox"/>
Aftercare Coordinator	<input type="checkbox"/>	<input type="checkbox"/>

ASAM Level 3.7	Employed Staff	
	Yes	No
Physician, NP and/or PA (on-site 5 hours per week, 2 hours on call)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist or Psychiatric NP (available 10 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse RN (on-site 56 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse LPN (on-site 112 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Facility Director (on-site 20 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>

Clinical Supervisor	<input type="checkbox"/>	<input type="checkbox"/>
Certified Counselors (Clinical SUD)	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Mental Health Clinician	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Staff (Recovery Coach)	<input type="checkbox"/>	<input type="checkbox"/>
Aftercare Coordinator	<input type="checkbox"/>	<input type="checkbox"/>

ASAM Level 3.7-WM	Employed Staff	
	Yes	No
Physician, NP and/or PA (on-site 20 hours per week, 4 hours on call)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist or Psychiatric NP (available 8 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse RN (on-site 56 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Nurse LPN (on-site 112 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Facility Director (20 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Supervisor	<input type="checkbox"/>	<input type="checkbox"/>
Certified Counselor (Clinical SUD)	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Mental Health Clinician	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support Staff (Recovery Coach)	<input type="checkbox"/>	<input type="checkbox"/>
Aftercare Coordinator	<input type="checkbox"/>	<input type="checkbox"/>



I hereby certify that all information contained in this document is true and accurate. I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreement that I have or may enter into with MDH and/or its contractors.

In compliance with the MDH Provider Attestation Form, the Facility attests that it will permit only staff members who are fully licensed and/or meet MDH program requirements to see and treat Medicaid eligible members.

I hereby give permission and consent for MDH and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to MDH and/or its contractors, of all information relevant to the evaluation of my ability to render addiction recovery and treatment services in a cost-effective manner and my moral and ethical qualifications, and agree to hold harmless any such person or organization from any cause of action based on the release of such information to MDH and/or its contractors.

By signing this attestation I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement.

**Printed Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If you have any questions please contact program staff at:**  
[mdh.bhenrollment@maryland.gov](mailto:mdh.bhenrollment@maryland.gov)