Government of the District of Columbia

Vincent C. Gray
Mayor

APPLICATION FOR CERTIFICATION OF ACCESS TO RECOVERY PROGRAM

Department of Health
Addiction Prevention and Recovery Administration

DC CORE Program is an Access to Recovery Grant No. 1H79TI023127-01
Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)

DC CORE ATR III Program
Access to Recovery Provider Application

Instructions

Please type or print legibly and submit one complete application packet (including attachments – see section X) for each physical location to:

District of Columbia Government
Department of Health
Addiction Prevention and Recovery Administration
Office of DC CORE ATR Program
1300 First Street NE, Room 313
Washington, DC 20002

Retain a copy of the completed application for your files.
Questions can be directed to:

Frances Buckson
Chief of the Office of Certification and Regulation
(202) 535-1825
Frances.Buckson@dc.gov

By signing below, you certify that the information provided in this application, including the attachments is correct and true to your knowledge and you have the authority to represent this organization on this application.

_____
Print or Type Name

_____ _____ _____
Signature ***Title or Position*** ***Date***

BASE REQUIREMENTS FOR CERTIFICATION

An applicant for certification to provide recovery support services must demonstrate that:
(a) It has a clear mission/purpose statement that describes the type of recovery support service(s) it intends to provide;
(b) It offers an organized program which outlines how services will be provided with an evidence based curriculum, who will provide the services, and how direct linkages to support agencies will be executed;
(c) It has appropriate staff and facilities to provide the intended recovery support services;
(d) It has appropriate billing and financial record keeping capabilities; and
(e) It has a quality improvement plan that includes standard performance measures.

I. ORGANIZATION IDENTIFICATION INFORMATION	
Organization Name:	
Main Office Mailing address:	Ward:
Main Office Phone number: Fax number:	E-mail address: Website:
Client Services Site address: Phone number: Hours of operation:	Client Services Site address: Phone number: Hours of operation:
Name and title of organization's Director/Manager:	Client Services Site address: Phone number: Hours of operation:
Date of incorporation/established:	Number of staff in organization: Number of staff designated for the ATR Program:
Current number of board members or governing body members (if applicable):	Name and contact information of president or chairperson of governing board:
Name and contact information for person responsible for the ATR certification:	Chapter 23 Certification Number (if applicable): Mental Health Certification Number (if applicable):
Please complete if program information is different than above:	
Clinical or Recovery Support Program Name:	
Onsite Program Director: Phone Number:	
Assistant Director or additional staff contact: Phone Number:	
Is this facility: Owned ____ Rented ____ Private Agreement _____ *If under a private or rental agreement, please attach the agreement.*	

II. ADDITIONAL ORGANIZATION INFORMATION

Check box if your organization: *(check all that are applicable)*

- ☐ Offers American Sign Language interpretation
- ☐ DD/TTY (Telecommunications **D**evice for the **D**eaf/**T**ele**TY**writer)
- ☐ Handicapped parking and Wheelchair accessible
- ☐ Childcare services
- ☐ Offers Private Transportation
- ☐ Location near public transportation (bus or metro line)
- ☐ Food and clothing support

Check box if you provide services for: *(check all that are applicable)*

- ☐ Men ☐ Women ☐ Pregnant women ☐ Families with children ☐ Homeless
- ☐ Adolescent/Youth ☐ LGBTQ
- ☐ Persons involved with the child welfare system ☐ Persons involved with the criminal justice (CJ) system
- ☐ Persons who are developmentally/physically disabled ☐ National Guard and Veterans
- ☐ Persons with co-occurring mental health and substance abuse disorders ☐ Persons with HIV/AIDS
- ☐ Non-English speaking persons. If so, which languages?_____

Disclosures ***(When answering the following questions the word "you" refers to the President, CEO or any other title given for the administrator responsible for this organization)***

Have you or your organization ever lost a professional certification or licensure for failure to maintain required standards, misconduct, or any other reason?

☐ Yes ☐ No

If yes, please explain.

Do you or does your organization have any current or pending litigation against it?

☐ Yes ☐ No

If yes, please explain.

Do you or does your organization owe any debt to the IRS or any other state or local government?

☐ Yes ☐ No

If yes, please explain.

III. TYPE OF ORGANIZATION

Please place a check mark in the sections that best describes your organization.

Chapter 23 Certified Substance Abuse Treatment Provider ☐ Certified Level of Care (check all that apply): Level 1 ☐ Level II ☐ Level III ☐	Department of Mental Health Certified Provider ☐	Community-Based/Grass roots ☐

For-profit ☐	Not-for-profit ☐	Faith-based ☐

* If faith-based, please list or describe the faith associated with your organization. This information will be included in our provider directory so that clients can make a more informed choice about the program(s) they choose to attend:

IV. CURRENT CERTIFICATIONS/LICENSES

TYPE	License/Registration or Certificate Number	Expiration Date
Certificate of Occupancy		
Currently licensed under other District of Columbia governmental law or regulations, i.e., Basic Business License (Please Specify) _____		
Currently licensed/certified to provide Child Care under Title 29, Chapter 3 of the DC Municipal Regulations		
Current certification from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) for the treatment of drug abuse, alcohol abuse, or mental illness (If Applicable)		
Current certification for the Commission on Accreditation of Rehabilitation Facilities (CARF) (If Applicable)		
Current certification from the Council on Accreditation (if Applicable)		
Currently certified as eligible for Medicaid reimbursement as a free standing mental health clinic or substance abuse treatment program (If Applicable)		
Currently approved by the Substance Abuse and Mental Health Administration as meeting its standards for drug and/or alcohol facilities (If Applicable)		
Currently registered with the DEA (If Applicable)		
Other (Please specify)_____		

V. PHYSICAL DESCRIPTION OF FACILITY

Type of Building *(please check one)*

☐ House: Number of Floors _____
Single Family _____
Detached _____

☐ Office: Office No.:_____; Floor(s) Occupied_____

Total number of floors in the building _____

☐ Church: Room #_____; Floor(s) Occupied _____

Total number of floors in the building _____

☐ Trailer: Number of Rooms _____ Size/Square footage: _____

☐ Other (Explain)_____

Building Construction

☐ Brick ☐ Frame ☐ Masonry

☐ Concrete ☐ Steel ☐ Other _____

Rooms

List each room in the facility, beginning with the first floor and move up. Indicate if the room is or is not being used by the program. If it is used, indicate its use. If an entire floor is not being used by the program you can indicate that in the following manner: First Floor – Church Sanctuary.

Room	Floor	Use

Facilities Checklist		
Check if operational	**Inspected Item**	**If corrections are needed, date to be completed**
	Facility décor is appropriate and presentable for population (e.g. furniture, pictures, carpeting, lighting, wall colors, etc.)	
	Appropriate number of functioning bathrooms per client ratio	
	Appropriate heating and cooling systems (temperature)	
	All hallways and walk areas are clear of objects.	
	Flashlights are assessable and operational.	
	First aid kits are available and fully stocked.	
	All fire extinguishers are visible and fully charged.	
	All outside lights and smoke detectors are operational.	
	Water coolers (each level)	
	Exit and emergency signs and maps are posted at each exit and are easily visible.	

Please check all services you intend to provide:

Client Services		**If applicable, list target population**
Recovery Support and Care Coordination Services		
Recovery Support Evaluation (onsite intake and 6 months follow-up)		
Care Coordination		
Spiritual and Faith Based Support Services		
Spiritual Support Group		
Spiritual and Cultural Support Group		
Recovery Mentoring and Coaching Support Services		
Recovery Support Individual and Group Support		
Recovery Coaching and Mentoring		
Intensive Recovery Support (Relapse Prevention)		
Peer Coaching or Mentoring (adults, youth, and young adults)		
Educational and Life Skills Support Services		
Basic Education (GED)		
Education and Academic Skills Development		
Educational Coaching and Mentoring		
Community Employment Program		
Employment Skills, Coaching and Work Preparation (re-entry skills)		
HIV/AIDS Education and Support		
Health and Nutritional Support		
Parent and Family Education Services		
Parenting Classes (male & female)		
Parenting Assistance (male & female)		
Family and Marital Counseling (conflict resolution skills)		
Family, Marital and Life Skills Education		
Family Support (parents/guardian and children)		
Child Care Services		
Child Care (children 13 and under)		
Transportation Services		
Private Transportation		
Public Transportation (Bus and/or metro pass)		

Recovery Social Activities - Community Reinforcement Approach (CRA)		
Environmental Stability (Offered on a limited basis)		

If a service you intend to provide was not listed, please provide the name and description of the service below:

_____

_____

_____

_____

VII. STAFFING

Staffing Capacity

How many staff will provide the client support services listed above?

Describe your staffing pattern, including staff that support clients services, financial and billing services, any clinical or counseling services, and administrative and management services (attach any additional pages and resumes as necessary).

What is the average client-to-staff ratio?

Approximately how many clients can the program serve?
(Client capacity)

What is the language fluency of staff?

Minimum Qualifications

Describe the minimum qualifications, education, experience, recovery time, and/or training required of staff:

Specific Qualifications, Training, and Experience of Staff

DUPLICATE THIS PAGE AS NECESSARY. ONE (1) PAGE FOR EACH STAFF PERSON.

Begin with the Program Manager and Clinical Director. All staff persons must complete the top half of the form. The bottom half of the form must be completed by all professional staff only.

Last Name of Staff Person	**First Name**	**Middle Name**

Title	**FTE**	**PTE** *(No. of Hours)*

Function: **Supervisory** ☐ **Non-Supervisory** ☐		
Duties:		
Employed or volunteer at another Substance Abuse Treatment Program ☐**yes** ☐ **no**		
Name of Program:	☐**yes** ☐ **no**	**Tour of Duty:**

The following section is to be completed by *professional staff only* requiring licensure/ certification, etc.

Educational Background		
Degree(s)	**Date Received**	**Name and Location of Institution**

Certificates, Licenses, Registrations (attach copies)	**Number**	**Expiration**

Background and Professional Experience

VIII. ACCOUNTING CHECKLIST

Person responsible for finances (give person's name, credentials and an outline of their responsibilities):

☐ Ability to have accounting staff trained on the APRA/ATR WITS/DATA electronic client data system (30 days after notification of program approval to provide services)

☐ Bank account is established to receive direct deposits.

☐ Ability to store financial records for five (5) years.

☐ Ability to keep financial records locked in a secure location.

☐ Ability to set up individual client escrow accounts (Environmental Stability Program only)

- Ability to release client escrow funds within 48 hours of clients release

☐ Accounting processes are in place to account for the receipt and distribution of program and client funds:

- Money received from
- Date received
- Amount received
- Original amount billed
- Amount due
- Money distributed to
- Date distributed
- Amount distributed

IX. INFORMATION SYSTEM REQUIREMENTS For WITS/DATA

Providers are required to use IBM-compatible personal computers for data input and are required to have internet access.

How many computers does the organization have?

The minimum computer workstation requirements are described below. Place an "x" in the box next to each requirement the organization currently meets:

☐ Operating system: Windows XP Pro
☐ Computer processor: 450 mhz or higher
☐ Memory: 512 mb or higher
☐ Browser version: Internet Explorer 7.0 or higher
☐ Virus protection: Required and must be kept current
☐ Have access to a printer

X. ADDITIONAL REQUIRED DOCUMENTATION

Please include the following documentation in your application packet:

☐ Copy of chapter 23 certificate for Substance Abuse Treatment Facility (if applicable)
☐ Mental Health program certification (if applicable)
☐ Other certification applicable to substance abuse treatment & prevention services
☐ Organization's mission statement
☐ Summary of services to be provided with clear linkages to other support services
☐ Program Organizational chart
☐ List of ATR staff job descriptions (roles and responsibilities)
☐ List of board of directors or governing body members (if applicable)
☐ Program policies and procedures manual for providing substance abuse services (clinical and recovery support services)
☐ Organization code of ethics and statement of client confidentiality
☐ Client services curricula (evidence based) and services schedule (daily & weekly)
☐ Program performance measures
☐ Client grievance policy
☐ Continuous quality improvement policy
☐ Building occupancy and/or zoning permit
☐ Client Drug and alcohol testing policy
☐ Employee Drug and alcohol testing policy and procedure for employees working in Safety sensitive positions pursuant to DC Official Code §1-620.36.
☐ Program policy for evacuation (emergency or program scheduled move)
☐ Proof of appropriate driver licenses (individual drivers) and proper automobile insurance (if providing transportation)
☐ Program comprehensive liability insurance policy
☐ Letter of Good Standing (District of Columbia within the past 3 months)
☐ Clean Hands Act Certification Form (see attachment)
☐ Copy of Client Consent Form for client services to be rendered
☐ Policies and procedures for accounting polices
☐ Copy of most recent (within three years) independent audit and finances report (include management letters comment)
☐ Copy of Tax Certification Affidavit from the Departments of Employment Services and Tax and Revenue
☐ Copy of last 990 (nonprofits)
☐ Program sustainability plan
☐ W-9 Tax Form
☐ Statement of Organization services, contact person with address, telephone & fax numbers, and email or website address on program letterhead.

"CLEAN HANDS ACT"
CERTIFICATION FORM

TO THE APPLICANT:

PLEASE READ CAREFULLY AND COMPLETELY BEFORE SIGNING.

- A FALSE STATEMENT ON THIS CERTIFICATION REQUIRES THAT THE DEPARTMENT PROCEED IMMEDIATELY TO REVOKE THE LICENSE OR PERMIT FOR WHICH YOU ARE APPLYING, AND FINE YOU $1,000.00.

- THIS CERTIFICATION IS REQUIRED BY THE ***"CLEAN HANDS ACT OF 1996"BEFORE RECEIVING A LICENSE OR PERMIT*** (EFFECTIVE MAY 11, 1996, D.C. LAW 11-118, D.C CODE § 47-2861 et seq.).

I, _____, certify that _____,
(PRINT NAME CLEARLY) **(PROVIDER)**

does not owe more than $100.00 to the District of Columbia Government as a result of:

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Action of 1985, effective March 25, 1986 (D.C Law 6-100; D.C. Code § 6-2901 et seq.);

2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of (1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code § 6-2911 CL et seq.) ;

3. Fines, penalties or interest assessed pursuant to the Department of Consumer and Regulatory Affairs Civil Infraction Act of 1985, effective October 5,1986 (D.C Law 6-42; D.C Code § 6-2701 et. seq.); or

4. Past due taxes.

I understand that if I knowingly falsify this Certification, the Department will move to revoke the license or permit for which I am applying, and to fine me $1,000.00. I further understand that the Department may conduct an investigation to ascertain the veracity of this certification.

I understand that this Certification is now required as documentation to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

_____ _____
SIGNATURE OF APPLICANT **TITLE**

_____
DATE